S. HRG. 103-1003

CBO ANALYSIS OF THE MANAGED COMPETITION ACT

Y 4. F 49: S. HRG. 103-1003

CBO Analysis of the Managed Competi...

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

MAY 4, 1994

APR 14 1995

Printed for the use of the Committee on Finance

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CBO ANALYSIS OF THE MANAGED COMPETITION ACT

WEDNESDAY, MAY 4, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:04 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux, Conrad, Packwood, Chafee, Durenberger, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H–31, April 29, 1994]

FINANCE COMMITTEE SETS HEARING ON CBO ANALYSIS OF COOPER-BREAUX

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D–NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on the Congressional Budget Office (CBO) analysis of The Managed Competition Act, a health care reform proposal sponsored by Senator John B. Breaux (D–LA) and Representative Jim Cooper (D–TN). CBO Director Robert Reischauer will testify before the Committee.

The hearing will begin at *10:00 A.M. on Wednesday, May 4, 1994* in Room SD–215 of the Dirksen Senate Office Building.

"The Congressional Budget Office's reputation for impartial and thorough analysis is well-deserved," Senator Moynihan said in announcing the hearing. "The Committee looks forward to hearing Director Reischauer's testimony."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished witness, the irrepressible and omnipresent Director of the Congressional Budget Office, Dr. Reischauer. We meet this morning for the purpose of receiving the report from the Congressional Budget Office on the analysis of the budgetary implications of S. 1579, as I believe to be the case, the Cooper-Breaux Managed Competition Act of 1993. It is a bill sponsored in the Senate by our distinguished colleagues, Senators Breaux and Durenberger on the Finance Committee, and Senator Lieberman and Senator Nunn. It is also associated with Mr. Cooper of Tennessee on the House side.

For reasons which Dr. Reischauer declines to explain, the CBO study of the administration bill had a simple black band of no technical features whatever. Whereas, the Managed Competition Act shows you in a wholly modern and advanced hospital operating room, which may indicate it will be more expensive. [Laughter.]

Senator BREAUX. Better quality.

The CHAIRMAN. Better quality. And on that note, I turn to my colleague, Senator Packwood.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, I note that you referred to Dr. Reischauer as irrepressible, omnipresent, but you did not say omniscient. You do not often forget to add things. I will go on from here.

I hope Dr. Reischauer can comment on how soon we can have estimates on at least the other two major bills, Senator Chafee's and Senator Nickle's, both of which have significant numbers of cosponsors. It is very clear that the bill we pass is going to be an amalgam of all of those. I think we are going to have to have some estimates. I am not being critical. I do not know how you can in any speedy passage of time analyze these bills. But I think it is going to be difficult to move forward until we do have those analyses.

The CHAIRMAN. Well, I think that is literally, specifically the case. Then the CBO has the House as a client as well, and they will be making demands. We will hear about that from Dr. Reischauer.

Senator Breaux, this is your day. We welcome you to it.

Senator BREAUX. Where is Senator Durenberger when I need him?

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman. I thank Dr. Reischauer for being with us and for their major effort on trying to predict the unpredictable.

We have before us a detailed estimate as to what costs and liabilities the managed competition bill will produce if enacted as it has been introduced by myself and our colleague, Dave Durenberger, on the Finance Committee.

There are some things in it that I think are good news for those of us who advocate managed competition. I think it is important to note that for the first time CBO has scored a piece of legislation that relies on the marketplace as working to reduce costs. The report will clearly show that 18 million more people can be added to the insurance roles without employer mandates, without premium controls or price caps, and that this can be accomplished in the first year.

That would produce, according to the report, 91 percent of Americans having insurance under a marketplace, oriented, non-bureaucratic proposal by the year 1997. Our plan, of course, then says, let us take a look at how many people are uninsured at that time to see what else needs to be done and take action after we have had a chance to reform the health care system in this country.

I notice one of the preliminary reports in the Washington Post said this morning that Reischauer will say that the question of whether costs can be reduced under a managed competition bill will be highly speculative. That is not what the report says.

It clearly shows that under a managed competition market-oriented proposal, which we have, you can see cost increases being reduced by 1 percent, and they are projecting a 4-percent increase. That is a 25-percent reduction in the rate of cost increases with a system of managed competition. I think that is one of the most significant things that I have read in the report in that it recognizes that managed competition can produce cost savings without premium caps, without price controls that have not worked in the past.

The report also points out shortfalls in the funding mechanism. I would point out that we adjusted our bill from the last Congress, based on CBO's recommendation to make sure that we cover the cost that they said last Congress had not been met.

They have, and they will explain it, I am sure, re-estimated the cost of the program and, therefore, it predicts additional shortfalls. It also points out, like in every bill, the administration's as well as ours, that those shortfalls can be corrected in relatively simple legislative fixes and they discuss different fixes in that area.

So there are things that I think are very good news. There are things that are problem areas that they point out. And I think that they have provided a very valuable service to the committee. I thank them for the hard work that they have done, particularly in a very tight time frame.

But as we consider this, let me just share with everybody a quote that I think is appropriate—it was from the New York Times—as we consider all of these reports, on the Chafee bill, on the administration's bill, on Breaux-Durenberger, and what have you, it says that "it serves no purpose to work reform so that it fits rules that the CBO concocts to predict what cannot be predicted."

That is going to be true for whatever bill that we are going to be considering. I think that we have to be guided not just by restrictive rules, but rather by what we think is doable and what we think is realistic.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

I might make the point, just a general all-hands alert here, that we are facing this situation with respect to the implementing legislation for the Uruguay Round where the rules which you did not make, sir, require us to assume—to make up a loss of revenue from an increase in economic activity, but without any compensating increase in revenue that that activity generates. We have a real problem there, but we will get to that next.

The Majority Leader is present. We welcome you, sir.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, thank you very much for this hearing. Thank you for recognizing me. I would begin by thanking Dr. Reischauer for being with us today and for the effort his staff has put in to this analysis of the Cooper-Breaux bill.

I commend Senator Breaux and Representative Cooper for the leadership they have shown on this issue. As we all know, there are disagreements among us on how best to reach a decision. But

I think we all agree that we are trying our hardest to develop legislation that will effectively reform the health care system.

In reviewing Dr. Reischauer's analysis of the Cooper-Breaux bill, I believe a number of important conclusions can be drawn. First, those who believe that we can achieve universal coverage—that is to say that every American will be insured—without requiring such coverage are mistaken. Incremental reform, voluntary efforts will not solve the problem of the uninsured.

According to the Congressional Budget Office, if adopted, the Cooper-Breaux bill would cost $300 billion in subsidies in excess of the savings in the bill and still leave 25 million Americans without insurance.

Second, the CBO clearly points out that the basic structure of the bill is unworkable. The $300 billion cost of the bill cannot be absorbed by the health insurance plans as contemplated in the bill. Either taxes will have to be raised, spending cut or the deficit increased. If subsidies are lowered, the numbers of persons without insurance will be higher.

Third, CBO has not scored significant reductions in health insurance costs for managed competition. Although many of us believe that a restructured health insurance market that introduces better market incentives through managed competition will result in substantial reductions in health care spending, CBO will not give credit to such plans.

Something more is required, like the premium caps in the President's plan, the CBO to score substantial reductions in national health expenditures. Everyone should understand that comprehensive health care reform will not be easy. It is a very difficult issue. It is a very complex issue.

Almost 40 million Americans do not have health insurance. Health insurance costs are much higher in this Nation than in any other advanced industrialized nation and those costs continue to rise rapidly. There are no easy solutions. Tinkering around the edges with the current system will not work. Difficult decisions must be made. I hope we will make those decisions this year in a comprehensive and bipartisan manner.

I conclude by saying, Mr. Chairman, again, that I commend Senator Breaux and Representative Cooper and Senator Durenberger for their leadership in this area. We do have some disagreements on how best to achieve our goal, but we are united in identifying that goal.

Thank you.

The CHAIRMAN. Thank you, Mr. Leader. I am sure the committee will not object if I suggest that, Mr. Durenberger, this is your bill, too, and you might want to make some comments.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, I appreciate that. I was thinking on the way over how best to use a couple minutes, because it is impossible to characterize this in any way that makes any sense to anybody. I think Bob recognized that when he was here testifying on the impact of the Clinton plan.

One of the things that I will never forget that he said to us is, he cautioned us against trying to make health policy on the basis of CBO estimates and everybody in this place has now had 10 years of experience of doing that. In fact, some of us have had more.

If we had relied on CBO estimates back in 1983 when we were doing DRGs and obviously they did not take into account the consequences of tightening up on hospital payments, putting prices on hospitals what exactly the dollar impact that was going to have over on the Part B side when doctors and outpatient services went bonkers. So it is really a difficult task that we have and a difficult task that Dr. Reischauer has.

The way I have characterized where we are today in the health care reform debate is that it is like a builder who arrives appropriately on Monday morning when he is told to arrive on the scene of a building site and the concrete is over here, and the cement truck is over there, and the electrical stuff is piled up over there, and the lumber is piled up over here, and the subcontractors are lined up over there but there is no blueprint.

What we have in this variety of estimates are an estimate of the amount and quality of the lumber, an estimate of the amount and quality of the electrical, all of this. We are going through the parts of this sort of thing. And on the basis of our understanding of what these particular kinds of materials can do we are putting estimates on them.

But we have not decided yet exactly what it is we are trying to build. And until we do that, it is going to be a very, very difficult task. I will suggest to my colleagues that we have to make some decisions about what we are building.

We are either going to build on models that are being built in America today where health care costs are substantially lower than in other parts because medicine is practice differently; or, we are going to continue in the way we are now and just try to trim some costs as this report shows managed competition, managed care can take some costs out, but it does not give us any credit for actually changing the way medicine is practiced because it cannot. I do not know that it is capable of doing that.

So I think the real challenge is to get by this part of the process in comparing the estimate of one plan against the estimate of another plan and get on with making some decisions about whether or not we are going to set new rules for new behavior in the health care system in this country; and then just make the tough decisions and make them bipartisan and make them in this committee, and let us get on with it as quickly as possible.

The CHAIRMAN. The decision is modeled, as I believe you said, on health care practices that have emerged in different parts of the country that are now in place to a considerable degree.

Senator DURENBERGER. Yes. And it is a difficult thing, as I am sure it will be pointed out to us here today, it is difficult for a national estimating process to make assumptions that the behavior that we see in Deluth, MN today can be replicated somewhere else.

But we have talked about a report on behavior in Florida the way the doctors use MRIs compared with the way the same kinds of doctors working with the same kinds of people do it in Oregon.

It is a bio-factor of two or three different—a different way of practicing medicine means you get better care for less money in Oregon than you do in Florida. That is demonstrated time and time again all over this country.

The CHAIRMAN. We keep running into that.

Senator DURENBERGER. We have to find a way to encourage that kind of behavior.

The CHAIRMAN. Thank you, Senator Durenberger.

Senator Rockefeller?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WV

Senator ROCKEFELLER. Mr. Chairman, just a couple of comments. One is that it becomes what we all do around here. If CBO does not agree with what we want, we say, well, if they had been around in 1963 or 1983 they would not have been able to do this or that. I mean, the fact is, this is not then, this is now. Everything is a lot more sophisticated in the way of measurement.

I just think we had better take what they say very, very seriously. We certainly did on the Health Security Act—recognized that there were some mistakes in it that we had to correct, which we are prepared to do.

There is a lot of talk about, you know, about bipartisanship. I want to believe that and I do believe that. But at some point we are going to have to decide, are we really serious about setting in legislation 100 percent coverage and then it may be that we fall a couple of percent short of that because of problems we discussed before. Even Social Security does not arrive at 100 percent.

But are we really going to do health care? I mean, are we really going to do what the American people are saying they want us to do or are we going to advance a series of plans and then come up with a series of compromises that reflect the plans but not the original intent, either of the American people or——

I think of ourselves as a Congress. So this is something I guess I just worry about as I head into this testimony and I take what Bob Reischauer has to say very seriously. When he said some things about the Health Security Act I noted in my own personal behavior a kind of defensiveness.

But after a few days' reflection, that is the way he saw things and we figured that it was better to just try and adjust to that and make our plan better, which the Majority Leader has indicated a number of ways to do.

The CHAIRMAN. Which he has done.

Senator ROCKEFELLER. Yes.

The CHAIRMAN. Thank you, Senator Rockefeller.

Senator Daschle?

OPENING STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Mr. Chairman, thank you. I will be very brief. I also would like to commend CBO and thank them for their latest contribution to our understanding of the ramifications of each of the options before us.

Let me also commend our colleagues. Senator Breaux and Senator Durenberger have done this committee and the Senate a real service in bringing forth a proposal that has a good deal of merit. Fortunately, because we now understand the budgetary ramifications of this proposal, we are much more prepared to approach the tough decisions that the Majority Leader has indicated we must make.

My biggest concern as a result of the information provided is that Breaux-Durenberger would not attain the ultimate goal of universal coverage.

This lends support to my original conclusion that unless we have some combination of mandates and taxes, we will not reach universal coverage. We must acknowledge this conclusion however frustrating it may be, if, indeed, we are going to accomplish what the President said must be the bottom line with regard to successful health reform.

We have to achieve universal coverage. Cooper-Breaux-Durenberger does take a significant step forward, but 25 million Americans would still remain uninsured were we to adopt this plan as it has been presented. We can do better than that; and I am convinced we will.

The CHAIRMAN. Thank you, Senator Daschle.

Senator Chafee?

Senator CHAFEE. No comments. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Well, thank you, Mr. Chairman. I appreciate your having this hearing and I appreciate Mr. Reischauer being here and the analysis that has been made. I do have some difficulty with any health care approach that moves toward one model rather than the wide variety of models that we might properly avail ourselves of, and especially as much as I think managed competition has to be part of any health care plan. I question whether it should be the only part, because I think it is largely untested and untried,which is a conclusion I think the CBO arrives at as well.

But having said that I want to compliment Congressman Cooper, Senator Breaux and Senator Durenberger for trying to do their best to come up with an approach that may make some sense here. But my personal belief is that we have to go beyond this and we have to do it in a way that does not put all the eggs in one basket, which may not be a very good basket. It may be one of the good aspects of health care, but it cannot be the only one.

Those are just some of the thoughts that I have been worrying about. I look forward to the testimony here today. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hatch.

And now Senator Bradley.

Senator BRADLEY. Mr. Chairman, I do not have any opening statement.

The CHAIRMAN. Fine.

Senator Conrad?

Senator CONRAD. I will wait.

The CHAIRMAN. Good. Very well.

Then at long last, at length and in good time, Dr. Reischauer.

STATEMENT OF ROBERT D. REISCHAUER, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. REISCHAUER. Mr. Chairman, Majority Leader Mitchell, and members of the committee, I appreciate the opportunity to appear before you again to share with you CBO's analysis of the Managed Competition Act of 1993. With your permission, I will submit my prepared statement and a copy of the report that we are releasing today for the record of this hearing.

The CHAIRMAN. That will be done and you proceed exactly as you wish.

[The prepared statement appears in the appendix. The report was made a part of the official files of the committee and is also available from the Congressional Budget Office.]

Dr. REISCHAUER. My summary remarks will focus on four topics. First, I will review the features of the Managed Competition Act that are important to our analysis. Second, I will explain CBO's assumptions about the effect that the competitive environment created by this proposal might have on the growth of health care costs. Third, I will report CBO's estimates of the proposal's impact on the number of uninsured people in America, national health expenditures, and the Federal budget. Finally, I will discuss some of the problems that might arise in trying to implement the Managed Competition Act as it is currently written.

Before I start, however, I want to reiterate the caution that I raised when I appeared before this committee in February to discuss the administration's health reform proposal.

As I warned then, a great deal of uncertainty surrounds estimates of any fundamental health reform proposal. This uncertainty is particularly great for the Managed Competition Act because key elements of the new system, such as the standard benefit package, are left unspecified and because managed competition is an approach that is largely untried at this point.

The full consequences of this proposal, as was the case with the administration's initiative, may not be felt for over a decade. During that time, markets will evolve and behaviors will change gradually in response to the new incentives that are created by this system. It is very difficult to say what the ultimate outcome might be.

Let me begin by providing you with a thumbnail sketch of the Managed Competition Act. The proposal would make health insurance available to all but would not establish universal coverage. In other words, there would be no individual or employer mandate. All employers would, however, have to offer but not pay for coverage for their workers.

Insurance markets would be restructured. Employees of firms with 100 or fewer workers and individuals with no attachment to the labor force would purchase coverage through regional health plan purchasing cooperatives. These health plan purchasing cooperatives would offer consumers a choice of accountable health plans with modified community-rated premiums.

These plans would provide a standard benefit package that would be specified by a national commission, but supplementary insurance could be purchased separately. Firms with more than 100 employees would have to offer their employees the opportunity to purchase coverage either by setting up their own accountable health plans—by that I mean self-insuring—or by purchasing coverage from a plan offered in a non-health plan purchasing Cooperative marketplace.

The proposal would provide people with strong incentives to purchase health insurance prudently by limiting the tax deductibility of premiums to the amount charged by the lowest cost plan offered through the health plan purchasing cooperative that enrolled a significant percentage of the eligible population.

The proposal would encourage insurance coverage by extending tax subsidies to the self-employed and people purchasing individual policies, and by creating a broad system of Federal subsidies that would replace the Medicaid system. Full subsidies for premiums would be available for those with incomes below the poverty level. Partial premium subsidies would be available for those with incomes between the poverty level and twice the poverty level. People with incomes below 200 percent of the poverty level would be eligible for cost-sharing subsidies that would ensure that their out-of-pocket costs were nominal. Those with incomes below 100 percent of poverty would also be eligible to receive a package of wrap-around benefits—that is, additional benefits that would not be part of the standard benefit package.

Spending on these subsidies would be limited to the amounts generated by the proposed reductions in the current health care programs—primarily by eliminating the Medicaid program—by the revenue changes, and by other savings measures. If insufficient funds were available to fund the subsidies fully, low-income participants would not be required to pay more. Rather, the health plans would have to absorb the shortfalls. They would receive only partial subsidies, in other words, and would somehow have to cope with the unpaid balance.

With this description in mind, let me now turn to the assumption that CBO made about the proposal's potential to curb the growth of health care costs. The Managed Competition Act has no premium caps, price controls, or global budgets. Nevertheless, the proposal calls for a restructuring of insurance markets and changes in the tax code, which are likely to dampen the growth of health expenditures somewhat. Yet because the managed competition approach has never been tested anywhere before, there is no empirical or analytical basis on which to estimate the size of this effect.

In a recent study, CBO identified the features of the managed competition approach that together could act to slow the growth of health expenditures. The Managed Competition Act incorporates in part or in full seven of the eight features that we identified. As a result, CBO has assumed for the purposes of its cost estimates that competitive forces would dampen the growth rate of health plan costs by gradually increasing amounts that would reach 1 percentage point after the year 2004.

In addition, we assume that increasing enrollment in effectively managed health plans would slow the growth in costs of account-

able health plans by 0.6 percentage point each year for the first 5 years. I want to emphasize that these assumptions remain largely matters of speculation.

Let me turn now to the third topic—that is, the fiscal impact of the managed competition proposal.

The CHAIRMAN. Dr. Reischauer, did you want to use the term speculation or did you want to try a more precise mathematical assertion, given that you had to make certain arbitrary assumptions and out of those assumptions came these estimates?

Speculation seems a more fanciful activity than we associate with the Congressional Budget Office. [Laughter.]

Dr. REISCHAUER. Well, the Congressional Budget Office usually bases its judgments on empirical evidence and the analysis of scholars and our own researchers. What I was trying to point out is that there is no available evidence of that sort on which to base an assumption like this.

The CHAIRMAN. You just had to choose.

Dr. REISCHAUER. We had to choose what we thought was a reasonable assumption. There is a lot of disagreement in the academic community about this issue.

The CHAIRMAN. Sure.

Dr. REISCHAUER. I think it is fair to say that the incentives and restructured markets created by this proposal would have some effect—clearly greater than zero. How much of an effect, though, is a very uncertain matter, one that will, in large measure, be determined by the changed expectations that the American public might develop over time—the changed patterns of behavior that might affect the provision of care, as Senator Durenberger said.

We really do not know how far these changes will go. They could go almost no distance at all, or they could be considerable.

The CHAIRMAN. Fine. Thank you.

Dr. REISCHAUER. Let me turn now to the third topic—that is, the fiscal impact of the managed competition proposal. This impact is highly uncertain because key elements of the proposed system, most notably the standard benefit package, are unspecified.

Faced with this situation, CBO has estimated the financial effects of the proposal under two illustrative alternatives. The first is a comprehensive benefit package similar to that proposed in the administration's Health Security Act. The second is a spartan benefit package costing 20 percent less than the first. As I will discuss later, we believe that neither alternative would be viable without further adjustments to the proposal.

Under the more comprehensive alternative, the number of uninsured people would drop by almost 40 percent in 1996—from 39 million to about 24 million. The uninsured would then constitutes less than 10 percent of the population for the balance of our projection period.

National health expenditures would rise above CBO's baseline initially, reflecting the increase in the number of people with insurance. But they would fall below the baseline once the effects of managed competition, more enrollment in managed care, and the cuts in the Medicare program began to be felt. By the year 2004, national health expenditures would be $30 billion, or about 1.5 percent, below CBO's baseline level.

Senator PACKWOOD. Could I ask just a question there? With the President's plan, that was, what, 1 percent below baseline?

Dr. REISCHAUER. By the year 2004, it would be 7 percent below the baseline—$150 billion.

Senator PACKWOOD. Thank you.

Dr. REISCHAUER. Under the comprehensive alternative, the cost of the various subsidies would far exceed the funds designated for them. Between 1996 and the year 2000, the average annual shortfall would be over 30 percent of the subsidies for premiums for non-Medicare enrollees.

The proposal would require health plans to absorb these shortfalls in subsidies. If one assumes that this mechanism works in dealing with subsidy shortfalls, it follows that the Managed Competition Act would have little appreciable impact on the Federal deficit. But that assumption, as I will explain later, is probably not a very reasonable one.

Under the less comprehensive benefit package, the number of uninsured people would be about the same as under the first alternative. As before, national health expenditures would rise in the early years but by less than under the comprehensive alternative. They would then fall about $50 billion, or 2.25 percent, below CBO's baseline level in the year 2004.

Under CBO's assumptions, which included a reduction in the generosity of the subsidy scheme called for in the proposal, the cost of the subsidies under the spartan benefit package would roughly equal the available resources. In other words, there would be no significant shortfall in subsidies.

Let me conclude my summary remarks by discussing two problematic aspects of the Managed Competition Act. The first of these is the considerable administrative challenge that would be faced by the national Health Care Standards Commission. This commission would be responsible for determining eligibility for premium, cost-sharing, and wraparound subsidies as well as ensuring that the health plan purchasing cooperatives and accountable health plans were paid their proper subsidy amounts.

The commission could receive well over 40 million applications and renewals each year and an equally large number of reconciliation or year-end income verification forms. The administrative tasks involved in determining the proper subsidy for each applicant would be monumental.

This can best be understood by realizing that the subsidy amount would depend on the applicant's state of residence, income, family status, and age as well as on the reference premium for the relevant health plan purchasing cooperative and the contribution, if any, that any employer might make on behalf of that applicant. Gathering together this information and calculating the amount of the subsidy would be a complex undertaking.

The commission would have additional daunting day-to-day functions involving registering and overseeing thousands of accountable health plans, including those established by self-insured firms. It would also have to design and implement a system to ensure an equitable distribution of premium and cost-sharing subsidy shortfalls to the plans and to the health plan purchasing cooperatives. Whether such a system is feasible is an open question.

A second particularly problematic feature of the managed competition proposal is its mechanism for ensuring that its subsidy costs do not add to the deficit. As I noted earlier, if the Health Care Standards Commission specified a comprehensive benefit package, the subsidy cost would far exceed the available resources, and the premium subsidies would have to be scaled back.

Health plans would be forced to cope with this shortfall as best they could. CBO believes that shortfalls of the magnitude that I mentioned earlier—that is, about 30 percent—could seriously undermine the orderly functioning of the health plan purchasing cooperative marketplace, possibly rendering the cooperatives inoperable. And even with full funding of the premium subsidies, health plans in health plan purchasing cooperatives could face shortfalls and uncertainties because of certain design features of the premium and cost-sharing subsidies.

One might assume that the disruption caused by shortfalls in the premium subsidies could be avoided if the commission adopted a more limited package of benefits, such as the one we specified for our second alternative. But this approach would create equally vexing problems under the provisions of the Managed Competition Act. If cost sharing was increased in an effort to reduce premiums, Federal expenditures for cost-sharing subsidies would rise. If coverage of services was scaled back, the costs of the wraparound benefits would rise. In other words, as you cut back premiums to reduce the size of the premium subsidies, the costs of other subsidies in the plan begin to rise.

As a result, to eliminate the possibility of subsidy shortfalls under the provisions of the bill as it is written now, the commission would have to adopt a benefit package that most Americans would regard as inadequate. For example, CBO's less comprehensive alternative had only limited hospital coverage and did not cover prescription drugs, dental care, mental health, or preventive services. Yet even these cutbacks, which run contrary to the proposal's requirements that preventive care and medically necessary services be covered, would not be sufficient to avoid significant shortfalls in the subsidies.

Consequently, CBO also had to eliminate the cost—sharing subsidies for those with income between 100 percent and 200 percent of the poverty level to make the proposal roughly deficit neutral without hitting the plans with an across-the-board reduction in their expected premium subsidies.

Let me conclude by noting that some of the difficult issues that must be resolved by this committee and the Congress are illustrated by the differences between the Managed Competition Act and the administration's Health Security Act.

One is the degree to which health reform legislation that you pass should specify the details of the new system. The administration's proposal provides answers to virtually every question. The Managed Competition Act leaves key features to be decided by commissions, boards, or the Congress after the reform is enacted.

A second issue is the extent to which market forces as opposed to explicit budget constraints, should be used to slow the growth of health expenditures. The administration's proposal relies largely on premium caps for which there is some international experience,

whereas, the Managed Competition Act depends on market forces largely motivated by tax caps and reflects an approach that really has not been tried anywhere before. So a good deal of uncertainty surrounds the effectiveness of that approach.

A third issue is whether participation should be voluntary or mandatory. The administration's plan requires all to participate and thereby achieves universal coverage. Participation under the Managed Competition Act is voluntary. It provides universal access to affordable insurance but does not provide universal coverage.

On each of these issues, as well as others, solid arguments can be made on both sides. There are no right or wrong answers. But as you continue to deliberate and debate these issues, we at the Congressional Budget Office will do our best to provide you with whatever information and analyses that we have available. We look forward to working with you on this major problem.

The CHAIRMAN. Dr. Reischauer, we thank you very much for that offer and for that statement. It was very clear, very lusive. I wonder if we could begin by saying that I have a feeling that about the last third of your statement was finished around midnight and we do not have it. We would be very much appreciative, if we could get the text. We would be grateful to you for that. I am sure we shall.

Once again, as is the courtesy of the committee, the Majority Leader.

Senator MITCHELL. Mr. Chairman, thank you very much.

Dr. Reischauer, thank you very much for your testimony. I would like to ask you a few questions about your analysis of the bill which is known as the Managed Competition Act.

In your analysis you estimate that if the benefits package under that Act is comparable to that contained in the President's plan it would increase the deficit by $300 billion over the next 10 years, absent offsetting provisions. The subsidies in the bill would exceed the savings by $300 billion. Is that correct?

Dr. REISCHAUER. If the subsidies are fully funded, that is correct.

Senator MITCHELL. Now despite those large subsidies and that huge increase in the deficit, by the end of this decade under your analysis 25 million Americans would still be without health insurance. Is that correct?

Dr. REISCHAUER. That is correct.

Senator MITCHELL. And if in order to reduce the costs of the bill the subsidies to lower income families were reduced, that would leave even more than 25 million Americans without insurance. Is that correct?

Dr. REISCHAUER. That is a difficult question to answer. If the generosity of the subsidy system was reduced, that would be correct.

Senator MITCHELL. But as I understand the bill, low income families would still receive the bill for the cost of the health insurance, but the health plans would have to absorb the cost of those subsidies in the form of higher premiums on everyone else or reduce reimbursements to providers, or alternatively Congress could go back and cut spending or raise taxes. Is that correct?

Dr. REISCHAUER. Yes; those are the options.

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Senator MITCHELL. Now with respect to other options you referred to a less comprehensive or I believe you called it a spartan plan of benefits. Am I correct that the benefits under this plan would be less generous than those enjoyed by 90 percent of those persons who now have health insurance in this country; is that correct?

Dr. REISCHAUER. Of people with privately provided health insurance; that is correct, sir.

Senator MITCHELL. Privately provided health insurance. That is correct.

And am I correct that such a plan would not cover mental health services, it would not cover prescription drugs, it would not cover preventive health services; is that correct?

Dr. REISCHAUER. That is correct.

Senator MITCHELL. And am I correct that under such a plan hospital coverage would be severely limited?

Dr. REISCHAUER. Yes; I believe that the package we put together would not provide coverage beyond the 15th day in the hospital.

Senator MITCHELL. Am I correct in my understanding that under this spartan plan, therefore, that if a person were in the hospital for more than 15 days that person would be responsible for paying the cost of that hospital bill for any stay in the hospital in excess of 15 days?

Dr. REISCHAUER. That is correct. But we would assume that if the spartan benefit package, the more limited benefit package, was the one provided, many Americans would purchase supplementary insurance.

Senator MITCHELL. But the coverage under this plan would be limited to 15 days?

Dr. REISCHAUER. Yes.

Senator MITCHELL. So, therefore, am I correct that under such a plan most Americans who have health insurance would have less coverage than they have today?

Dr. REISCHAUER. Less coverage from the basic plan, yes.

Senator MITCHELL. Yes, the basic plan.

Now, Dr. Reischauer, I had one more question I wanted to ask and it deals with a statement in your analysis. I quote, and I am going to read you the quotation and ask you to elaborate on that if you might explain it in more detail.

You state, and I quote, "The estimates of health insurance coverage and national health expenditures assume that the premium assistance specified in the proposal is fully funded either through additional spending cuts, tax increases or borrowing. Failure to fund the subsidies could result in an upward spiral of health insurance premiums, declines in health insurance coverage,and, potentially, the collapse of the HPPC system."

Can you elaborate on that statement, please?

Dr. REISCHAUER. If the subsidies expected by the plans were not forthcoming in full, the plans would be left with a shortage. Their response to that shortage would probably be a combination of reduced payments to providers and increased premiums for nonsubsidized people.

This response would cause premiums for others in the system to rise. Some of those individuals would drop out of the system. As

a result, the risk pool that the insurance company had expected when it set its premium would change because in large measure the more healthy folks would choose not to participate. Consequently, a good deal of instability could develop within this insurance marketplace that could unravel the entire system.

But as I said, the statement in our report is based on a generous benefit package that is not fully funded. There are ways of overcoming that problem so that shortfalls do not occur, either by cutting back the basic benefit package or by raising revenue some other way.

Senator MITCHELL. I have one concluding question if I might have time.

The CHAIRMAN. Well, go right ahead.

Senator MITCHELL. Dr. Reischauer, I just want to make sure I understand this. The Managed Competition Act as introduced does not specify the benefits package for the health insurance to be provided. Under the Act it is to be determined at a later time; is that correct?

Dr. REISCHAUER. Yes. A national Health Care Standards Commission would be established and would decide on a benefit package that would then be placed before the Congress. The package could be rejected by a joint resolution but not amended by the Congress.

Senator MITCHELL. Right. So in order for you to estimate the cost of the subsidies proposed under the plan you had to assume a certain level of benefit; is that correct?

Dr. REISCHAUER. That is correct.

Senator MITCHELL. And you made two different sets of assumptions. On the one hand, you assumed a level of benefits comparable to that contained in the Health Security Act at the request of the President; is that correct?

Dr. REISCHAUER. Yes.

Senator MITCHELL. And on the other, you would see a lower level of benefits. You referred to it in various terms, but an alternative level of benefits, less comprehensive. And if the benefits package comparable to the President's plan were included under this Act, then the deficit would be increased by $300 billion over the next 10 years absent other offsetting provisions. Am I correct in that understanding?

Dr. REISCHAUER. It would increase if the automatic reductions in subsidies were not implemented.

Senator MITCHELL. That's right. And under the alternative benefits package, if adopted, it would limit hospital stays to 15 days coverage, would not cover prescription drugs, would not cover mental health, would not cover preventive health, and would be less generous in terms of benefits than that enjoyed by 90 percent of Americans who now have private health insurance. Is that correct?

Dr. REISCHAUER. Correct.

Senator MITCHELL. Thank you, Mr. Chairman. I have no further questions.

The CHAIRMAN. Thank you, Mr. Leader.

Senator Packwood, the ranking member.

Senator PACKWOOD. Dr. Reischauer, in February you indicated we could not get to universal coverage without mandates of some

kind. I am quoting from your February statement. I say, "You will not get there by invitation, only by mandate. Do you agree with that, Dr. Reischauer?"

"Yes, I think you can get very close, but you are not going to get there."

You have us getting to 90 percent of coverage under Breaux-Durenberger. I will confess, I have been a supporter of mandates. I have heard Dave Durenberger say that given a good voluntary program and a good invitation we will get close. But you are estimating we are going to get to 90 percent under Breaux-Durenberger of covering of all the people.

Dr. REISCHAUER. Yes.

Senator PACKWOOD. I know that leaves 25 million uncovered. Hawaii apparently has some place, depending whose estimate you take, between 4 and 7 percent uncovered with an employer mandate and a SHIP plan in the State and Medicaid.

So even without a mandate we are not far off of the Hawaii total which is a mandate. You are talking about a difference maybe, if you are talking about 91 percent versus 94 percent, a difference maybe of 4 to 5 million people. I do not want to minimize that. But in a population of 260–70 million you are not far off. Am I correct?

Dr. REISCHAUER. That is right. And you could add to this Managed Competition Act aggressive outreach and enrollment of low income people and make some adjustments in the nature of the application process for subsidies and probably increase these percentages a percentage point or two quite easily.

Senator PACKWOOD. We could get close to Hawaii.

Dr. REISCHAUER. Yes.

Senator PACKWOOD. In that case, why go for a mandate?

Dr. REISCHAUER. That is a judgment for you to make, not for me to make.

Senator PACKWOOD. I understand that. And as I indicated, I have supported mandates. But no one likes mandates in and of themselves for the fun of it. If you can get what we pretty much all agree is universal coverage, none of us are thinking we are going to get to 100 percent—Hawaii does not get to 100 percent—if you can get close to it without the compulsion, why have the compulsion? What is the advantage of mandates for the sake of mandates?

Dr. REISCHAUER. Well, for the sake of mandates, there is no reason to have them. As you say, nobody would say, "Hey, let us have a mandate; they are fun." You are trying to achieve something. What you are trying to achieve is an equitable distribution of the costs and the benefits of health insurance. To the extent that you allow some folks to escape participation in the system, by and large those folks will be relatively healthy. Nevertheless, they will suddenly become players in the system when their health begins to deteriorate. It is like saying, "Why buy fire insurance until the year that your house is going to burn down?" That is not a practical way of allowing people to buy health insurance.

Then also, you know that if somebody who is not covered is struck by a car or becomes deathly ill, that individual will be brought into a hospital or a health facility of some kind, and we as a compassionate, rich society will not deny that individual the benefits that the rest of society has.

The way you avoid these two problems is by providing some kind of universal coverage. Whether the benefit you get from such coverage is worth the cost is really a judgment that is above my pay grade. [Laughter.]

Senator PACKWOOD. Let me ask you this. Is the kind of person that is uncovered qualitatively different then in Hawaii from what you would have under Breaux-Durenberger? Under Breaux-Durenberger are you going to have the healthiest or the best and the brightest or for whatever reason choose not to be covered and therefore you are going to skew the system? Whereas, in Hawaii those that are uncovered are more a random cross section that are left out by law, but not by exclusion themselves.

Dr. REISCHAUER. I do not know. I do not know who is uncovered in Hawaii.

Senator PACKWOOD. I do not either. I know the percentage or the estimate. I do not know who is uncovered.

All right, next question. Dr. Ellwood thinks we ought to have competing Health Plan Purchasing Cooperatives, Breaux-Durenberger does not. Do you have a personal opinion of what the cost estimates would be if you had competing Health Plan Purchasing Cooperatives?

Dr. REISCHAUER. No, we do not. But I just might say that the President's plan was complex. Breaux-Durenberger, in the sense that it allows for more flexibility and it leaves more aspects undecided in the legislation, is more complex. Senator Chafee's proposal is even less specific and leaves more options open, and preparing cost estimates for it will be even more complex. Nobody wants complexity for complexity's sake.

Senator PACKWOOD. Well, then let us be realistic. You have estimated it will take you probably another month to do Senator Chafee. That does not include Senator Nickles.

Dr. REISCHAUER. That does not include the House Ways and Means Committee or the Energy and Commerce committees either.

Senator PACKWOOD. Then let me just ask you a realistic question. How do we write a bill this year if in honesty we are going to wait for the estimates and you cannot do any better—I do not mean this critically—but you cannot do it any faster than what you are doing it?

Dr. REISCHAUER. I do not know. We are working as hard as we can. But this kind of estimating is very complex, and it takes a lot of time.

Senator PACKWOOD. I think your work is good and I do not mean the question critically. Either we or the House, Ways and Means Committee goes ahead in the dark or we wait.

Thank you, Mr. Chairman.

Dr. REISCHAUER. I might say that the issue before the Congress—writing a fundamental health care reform bill—is unlike anything that the Congress or the nation has ever done before. The expectations that many people have, based on how we change the Medicare program or make changes in the tax system, really do not apply to this undertaking. If you want the same types of cost estimates and impact estimates that you are used to having for normal legislative proposals, the pace at which the activity can proceed has to be much, much slower.

The CHAIRMAN. That is perfectly understandable and perfectly straightforward. I think I would like to just repeat now Senator Packwood's statement and your response, that this committee will want to have the estimate of Senator Chafee's bill and of Senator Nickles' bill, and then you have to do the Ways and Means legislation on the House side and Energy and Commerce; would that also be the case?

Dr. REISCHAUER. We are trying to provide support to House committees as they try and fashion the chairman's mark and alternatives to the chairman's mark at the same time that we are trying to do these comprehensive reports on specific bills.

The CHAIRMAN. On specific bills.

Dr. REISCHAUER. And it is very hard to keep all of these balls in the air at once. When you are taken off to do work on a proposal by the chairman of the Ways and Means Committee, you cannot also at the same time be analyzing the Chafee proposal.

The CHAIRMAN. Well, they have a certain constitutional priority, as we know. Would you want to estimate when we might get Mr. Chafee's proposal?

Dr. REISCHAUER. No. The last time I appeared before this committee, I said that we would have Cooper-Breaux done in 3 to 4 weeks. It is now 12 weeks later. I blew that estimate sufficiently that I should have no credibility on this question at all.

The CHAIRMAN. A factor of 3 or 4 to 12 is 4.

Senator DURENBERGER. Thanksgiving. [Laughter.]

Senator CHAFEE. Mr. Chairman, could I just ask Dr. Reischauer one question?

The CHAIRMAN. Please.

Senator CHAFEE. At the end of your last statement to Senator Packwood you said the pace will have to be more measured or slower or something. I am not sure what the word "pace" was referring to. You were previously describing how this was the biggest thing that we have ever undertaken in the Congress. Was the pace the integration of the system, bringing it in?

Dr. REISCHAUER. No. What I was talking about was the process of the Congress' putting together its proposals and deliberating them. You have before you a number of pure forms of health care reform—for example, your approach, the managed competition approach, the Nickles voucher-type approach. And before some committees act, they want to have a feel for the costs and the other ramifications of these proposals. Once they have all of that information before them, they would then like to sit down and fashion a compromise proposal or a proposal that rested on the best elements of the various approaches.

I am saying that it takes time for us to write all of these reports. Once you have all of them, you may want to say, "Let us do some modifications to this approach or that approach." When we analyze modifications for you on Medicare or Medicaid or food stamps or whatever, we are able to turn those estimates around in hours, possibly overnight. But a lot of the changes—amendments, modifications, and so forth—that are being proposed to these health reform approaches are the types of things that would send us back to the drawing boards and might require a week for an estimate. So the normal pace—the way the Congress and the committees usually de-

velop their proposals—just cannot be maintained if you want to rely on our numbers.

The alternative, of course, is that you could go ahead without the benefit of our numbers and see what happened when the bill hit the floor and we did our official cost estimate.

The CHAIRMAN. Sure. Having fully accepted the complexity and the difficulties, can I just make a cheerful note? Is that possible? No one would mind.

Senator ROCKEFELLER. It would be very helpful. [Laughter.]

Dr. REISCHAUER. I will cover up my ears so I will not hear it.

The CHAIRMAN. You suggested that under Mr. Breaux and Mr. Durenberger's bill the number of uninsured persons would drop by almost 40 percent in a year-and-a-half's time.

Dr. REISCHAUER. Yes.

The CHAIRMAN. And that would give us an insured population of somewhat over 90 percent of the population. That's pretty impressive.

Of the numbers who would remain uninsured in that 9.5 percent, or 24 million persons, 10 million would have incomes above 200 percent of poverty. Some would have incomes over 500 percent of poverty. The poverty numbers are——

Dr. REISCHAUER. This is on page 29 of our report, for anybody who wants to follow the chairman.

The CHAIRMAN. That is exactly right. We estimate that, you know, 200 percent of poverty under your table can go to $51,000 a year for a large family. There are not that many such families, but there are some. Otherwise, you would not bother to put it down here.

Well, we could do the hypothetical extreme and say if there was a family of eight at 500 percent of poverty, it would have an income of about $125,000 a year. Families with income of 500 percent of poverty and above it account for 1 million uninsured persons under the Breaux-Durenberger proposal. Well, that speaks of some choice in that matter; does it not?

Dr. REISCHAUER. Certainly, when we get up above 400 percent of poverty, remaining uninsured is a voluntary decision, and there is a real question about how much sleep society should lose over the choice of an individual not to sign up. But I would suggest that a family of eight with a $250,000 income who is uninsured right now is going to be difficult to find.

The CHAIRMAN. Or to persuade.

Dr. REISCHAUER. I mean, do not assign me the task to go out and find that family.

The CHAIRMAN. It is your table. But we would find ourselves in 1996 with only 4 million persons below the poverty level who are not insured and that would be a considerable achievement.

Dr. REISCHAUER. And in fact those individuals could have had their insurance paid for in its entirety under this system but for one reason or another did not sign up, did not fill out the forms, fell through the cracks somehow.

The CHAIRMAN. And that is just the one other point we would like to make. We have not quite settled it in our heads here, but when we speak of universal it is just not in the nature of things for that to mean 100 percent. There is just some friction. There is

always somebody who lives in a cabin in the Rockies and does not want to know anybody is there. There is always someone moving about.

Dr. REISCHAUER. But there are systems in the world—you know, in the United Kingdom, in Canada—where you can live in a cabin somewhere and engage in no act of your own and still be covered if you need care. By virtue of citizenship in the country, you are a participant in the system, and the system does not depend on individual premiums or employer-paid premiums. That dependence is what is getting us into this trouble.

The CHAIRMAN. I think you are speaking about a payer system——

Dr. REISCHAUER. Universal coverage is not hard to provide if you are willing to step away from the employment-based nature of our current system.

The CHAIRMAN. A single-payer system does that by definition. But we just also want to make the point, and we have to keep it in mind, that this is still something of a frontier society and there are an awful lot of unregistered folk and they get sick, too, and they get to hospitals, too. We have to provide for that reality. It is not the most disagreeable reality.

Now, Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman.

Thank you, Mr. Reischauer. The Majority Leader described a plan and asked you to comment on it. My question is, who put together the completely and totally unrealistic plan that we are referring to as the spartan-man plan?

Dr. REISCHAUER. CBO did.

Senator BREAUX. Is it anywhere in the bill that Mr. Durenberger and I asked you to take a look at?

Dr. REISCHAUER. No. As I said, there is no plan specified in the bill.

Senator BREAUX. And how is that plan in our bill to be written?

Dr. REISCHAUER. A national Health Care Standards Commission would develop a plan and present it to the Congress.

Senator BREAUX. And under our plan, who appoints the National Health Board to do that?

Dr. REISCHAUER. The President of the United States.

Senator BREAUX. Do you think it is realistic to assume that the President would appoint people to that Commission that would write the spartan type of plan that you wrote?

Dr. REISCHAUER. Well, I think the commission would be in a very difficult situation. It would have to decide whether to try and design a plan the subsidies for which would be fully funded, given the available resources, and which therefore would be a rather limited plan.

Senator BREAUX. Assuming the resources were made available.

Dr. REISCHAUER. If there were more resources available, I have no question at all that the plan would be closer to the average health insurance plan that most Americans enjoy now.

Senator BREAUX. But the spartan plan that we talked about, the spartan man plan, is really a hypothetical; is it not?

Dr. REISCHAUER. It is an alternative.

Senator BREAUX. A hypothetical alternative.

Dr. REISCHAUER. But so is the——

Senator BREAUX. But it does not exist anywhere; does it?

Dr. REISCHAUER. Oh, no. There are plans that are even chintzier than that. [Laughter.]

Ten percent of the covered population has something that is less generous.

Senator BREAUX. Sure. But as far as the Breaux-Durenberger bill, the spartan man plan, it is not in that bill; is it?

Dr. REISCHAUER. No, it is not; but neither is the comprehensive plan.

Senator BREAUX. That is right.

Now, trying to get a hold on some of the estimates from month-to-month is like grabbing jello. Let me tell you the two major examples I need you to comment on because we relied on CBO estimates a couple of months ago, last year, when we went back and we drafted our bill to take care of some of the problems that the last estimate pointed out to us.

When relying on those estimates a few months later with this report, we see that those estimates have changed dramatically. For instance, last year our employer tax cap was scored at raising $79 billion over 5 years. A few months later in this report this morning you say that that raises $25 billion over 5 years.

A second example, in July of last year, CBO released a paper talking about behavior with regard to managed competition. In that paper you stated that group and staff model HMOs reduced personal health expenditures by 15 percent from levels under traditional private health insurance plans. And assumed that enrolling additional people under these HMOs would reduce their health care on average by 7.5 percent.

This report, issued after the July report, reduces your estimate of these most effective HMOs to a 9 percent reduction in costs with an average reduction of 4 percent. So in one case we go from $75 billion over 5 years to $25 billion. And then here we go from a reduction in health care costs from 7.5 percent reduction down to 4 percent.

Now the problem Senator Durenberger, Congressman Cooper and I have is that we were relying on the last report, which was just in July, to craft the program that we have today. Can you give me some thought process on what happened in a matter of months?

Dr. REISCHAUER. All right. Let me start by saying that I think, as I said to you yesterday, some of the criticism of your approach is unfair in the sense that you and Congressman Cooper and other of the sponsors have indicated that once the cost parameters were known you would make other changes in this proposal.

The administration, of course, when it was crafting its plan, has a tremendous advantage in that the people putting together the plan have inside analytical and estimating capacity. So when the architects of that proposal had an idea that turned out to cost too much or to have untoward consequences, they were able to change their proposal without the glare of lights and television cameras on that process.

Members of Congress do not have that advantage. They have to put together a package without knowing what the costs and consequences are. We then estimate the package's costs and impact,

with the result appearing in public rather than being revealed in private.

As we have gone along in this process, our estimating tools, methodologies, and capabilities have improved. New information has come in. We will continue to change so as to provide you with the best estimates that we can provide.

On the second issue, the effectiveness of managed care, we have not changed our treatment at all since last year. It is described in slightly different ways, however, which may make it confusing.

With respect to the $79 billion in tax revenues that you referred to, that estimate was made by the Joint Committee on Taxation. As I said, we are not quite sure what has caused them to change their number to $25 billion, but my guess is that, like us, they are becoming increasingly sophisticated in their methods and the quality of their estimates is improving. We will investigate that further and get back to you, Senator.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. That would be helpful, just to ask Joint Tax. That is a big change from $79 billion to $25 billion. It comes as a bit of a disappointment to the sponsors. There is a reason and we would like to hear it.

Dr. REISCHAUER. Let me publicly thank the Joint Committee and its staff, for which you have supervisory responsibility. They have worked very hard and very well with us on this estimate.

The CHAIRMAN. Why do we not take this moment to have you introduce those good folk behind you here from CBO.

Dr. REISCHAUER. They are Jeff Lemieux, Scott Harrison, Len Burman, Nancy Gordon, Paul Van de Water, Linda Bilheimer, and Mark Desautels from the Congressional Budget Office.

The CHAIRMAN. Let us just give you a collective thanks from the committee.

[Applause.]

Dr. REISCHAUER. I think what they would like is a collective day off. [Laughter.]

The CHAIRMAN. I was going to say, that applause takes one week off the time it will take to get the Chafee bill done, right? [Laughter.]

Senator BREAUX. Mr. Chairman?

Dr. REISCHAUER. We've got it down to late October then. [Laughter.]

Senator BREAUX. I will conclude on this note. The point of why the estimate is so important on the tax cap, the difference in that estimate, is because the tax cap obviously is one of the ways that the Managed Competition Act would pay for new low-income subsidies. Last year it was $75 billion and this year it is $25 billion.

The CHAIRMAN. We will ask Joint Tax over.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman, very much.

I just want to reiterate that I think I have some idea of how this $79 billion came down to $25 billion. I think it is a very significant change. I think it is a change based upon meritorious consideration. And if it is correct, it throws substantial doubt upon those who look upon the tax cap as a way of paying for reform. That is my statement.

I would like very much, Mr. Reischauer, if you could just—I want to read to you some quotes from your own report and ask that you expand very briefly on each. On page 17 you say, "Under this alternative, health insurance coverage would probably be more limited for middle income people than for rich or poor."

Dr. REISCHAUER. That is a description of the situation that probably would develop under a very basic package of standard benefits. What would happen is that low-income people in America, particularly those below the poverty level, would have the standard benefit package plus cost-sharing subsidies plus wraparound benefits, leaving them with an adequate—if not more than adequate—level of benefits.

Upper income and some middle-income people would buy supplementary insurance to supplement the basic benefit package. They would be left with insurance coverage from the basic package plus the supplementary plan that probably would be comparable to what they have now.

Folks a bit above the poverty level—up to maybe two or three times poverty—would find that they were covered by the basic benefit package, but they would also find that the supplementary coverage was expensive. Some of those people, particularly those who were relatively healthy, would opt not to have supplementary coverage and would therefore be worse off than they are now with respect to insurance coverage.

So you would have an interesting pattern of insurance coverage: it would be adequate at low-income levels, and at high-income levels, and there would be a dip in the middle.

Senator ROCKEFELLER. Mr. Reischauer, on page 18 you indicate that "10 percent of workers who now have health insurance provided by employers for whom they would lose their health insurance."

Dr. REISCHAUER. There are incentives created under the subsidy system of the Managed Competition Act that would lead some employers to drop their employer-provided care so that their workers could take full advantage of the subsidies. Some of those individuals would choose to purchase coverage; others might decide to drop their coverage.

Senator ROCKEFELLER. You said "although the proposal would require health plans to absorb shortfalls and subsidies, shortfalls of that magnitude would cause turmoil."

Dr. REISCHAUER. The report suggests that if one had a comprehensive benefit package, the amount available for subsidies would be from 30 percent to 35 percent short of the total cost of those subsidies. Under the plan as it is now written, insurance carriers or plans would receive ratably reduced subsidy payments but would still have to offer low-income people a full benefit package. They would have to cope with the shortfall somehow, and we think their attempts to comply and react to it would—or could—lead to an unraveling of the insurance system, particularly within the health plan purchasing cooperative marketplace.

Much would depend on the ability of the national Health Care Standards Commission to design a system for sharing subsidy shortfalls equitably across all of the plans in the country. This would be a very difficult task because it would involve taking re-

sources away from self-insured companies and plans with more than 100 employees and distributing them to other plans within the health plan purchasing cooperatives. That redistribution would be a tough problem.

Senator ROCKEFELLER. In your executive summary you say, "Very large shortfalls in premiums could cause the Health Plan Purchasing Cooperatives system to collapse entirely because the amount that accountable health plans would have to pass on in higher premiums would be unacceptable."

Dr. REISCHAUER. If the distribution mechanism for subsidy shortfalls was ineffectual in distributing resources from the non-health plan purchasing cooperative plans to the plans in the health plan purchasing cooperatives, you could have premium shortfalls that would require plans in the health plan purchasing cooperatives to raise their premiums by as much as 30 percent. And, of course, the amount of the premium would affect the number of people who were interested in participating in the plans. It would also affect the dynamic of the marketplace in very uncertain ways, and we do not think that that it a viable alternative.

Senator ROCKEFELLER. Thank you, sir.

Mr. Chairman, on this issue of $79 to $25 billion on the tax projections, I am somewhat acquainted with how that came about. I have a written question that I want to submit to Mr. Reischauer.

The CHAIRMAN. Please do.

[The question appears in the appendix.]

The CHAIRMAN. If need be, we will ask the Joint Committee on Taxation to walk us through it.

Dr. REISCHAUER. We are already discussing this issue with them, and so we will get back to you on it.

The CHAIRMAN. There are no secrets here. There are some mysteries, but no secrets.

Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

Dr. Reischauer, I would like to go back to the questions raised by Senator Packwood, because I think he has put his finger on one of the key issues that we have to face with regard to attaining universal coverage.

Could you, for the committee, reiterate the percentage of people who are insured today?

Dr. REISCHAUER. It is roughly 85 percent.

Senator DASCHLE. That is my understanding.

And, again, the percentage of people you estimate would have been insured were we to pass the Clinton Administration bill?

Dr. REISCHAUER. That would be 100 percent.

Senator DASCHLE. Well, I guess we go back to the question that Senator Packwood was raising.

Dr. REISCHAUER. There might be some small gap in coverage—as you said, the non-compliant individual living on a mountain in Idaho.

The CHAIRMAN. Or an editorial writer for the Christian Science Monitor. [Laughter.]

Dr. REISCHAUER. I think the figure would still round to 100 percent, unless they had a very big editorial staff.

Senator DASCHLE. But, Mr. Chairman, this is a point that I think we need to explore. Senator Moynihan has indicated that Social Security participation is only 95 percent, even though it is legally mandated.

Dr. REISCHAUER. I do not think that is really—let me choose my words carefully.

The CHAIRMAN. Some employees are not covered.

Dr. REISCHAUER. Of the folks who were supposed to be covered by Social Security, I would guess that the coverage is 100 percent. To be sure, there is a little illegal activity that goes on, illegal employment, under which people are not covered. And then there are also groups of individuals, such as those who work for State governments, who have opted out of the Social Security system and who are not covered. Under the law, they are not supposed to be covered.

Senator DASCHLE. But my point is a serious one that addresses the legal and practical applicability of the definition of universal coverage. What some of our colleagues have been saying is that, although the legal applicability of universal coverage is 100 percent, the practical applicability may be only 95 percent. This means that if Cooper-Breaux reaches a 91 percent level of participation, we only fall 4 percentage short of what would be the practical applicability of universal coverage. This 4 percent shortfall is substantially different from a situation where the practical applicability of universal coverage is 100 percent, because then the Cooper-Breaux shortfall would be 100 percent. I would like, if you could, to elaborate on that definitional question.

Dr. REISCHAUER. My best judgment is that under a system like the President's proposal or a single-payer system, the practical number would be very close to 100 percent. It might be 99.7 percent, or something like that, but it is not going to be 3 percentage points less or anything large. Remember, though, that in the President's system you have both an employer mandate and an individual mandate.

Senator DASCHLE. Exactly.

Dr. REISCHAUER. And there are penalties for people who show up and want or need medical care but who have not been participants in the system. One would expect that, after a few years, one way or another, people would by and large all be included in the system. But then there are other costs, as everybody has noted, when you impose mandates.

Senator DASCHLE. Well, I would have characterized your answers to Senator Packwood as a minimization of the importance of universal coverage. I thought you said in one of your answers to Senator Packwood that under Cooper-Breaux we may actually get up to 92 or 93 percent, in which case we would be "almost there."

Dr. REISCHAUER. I do not think I said we are almost there. The question is, where do you want to go? He was saying you were almost there because he wanted to go to Hawaii. [Laughter.]

Dr. REISCHAUER. That is 95 or 96 percent.

Senator DASCHLE. Well, that is my reason in asking. You certainly would disagree that we are almost there with Cooper-Breaux. Is that a correct statement of your position?

Dr. REISCHAUER. Let me quote what is in our report. We have 39 million people who are uninsured. Forty percent of them would obtain insurance under Cooper-Breaux, and 60 percent would remain uninsured. That is not almost there.

Senator DASCHLE. Correct.

Dr. REISCHAUER. It is less than half of the way there.

Senator DASCHLE. Let me just in the 30 seconds I have left——

Dr. REISCHAUER. You would be in the middle of the Pacific.

Senator DASCHLE. It is more than just a percentage question, is it not?

The CHAIRMAN. No. No. Hawaii is in the middle of the Pacific. [Laughter.]

Dr. REISCHAUER. Actually, I do not even think it is in the middle.

Senator DASCHLE. For the record, I think the committee ought to explore other questions raised by our falling short of universal coverage. What happens to cost shifting? What happens to administrative complexity? What happens to the tendency of healthy people to opt out of the system?

Dr. REISCHAUER. That was in my answer——

Senator DASCHLE. I would hope that your answers reflect not only the number of Americans not being insured, but also the administrative and cost ramifications of this number.

Dr. REISCHAUER. I think in my answer to Senator Packwood I did raise those issues. There are individuals who are outside the system who then get sick and want coverage or care, and somehow the rest of the system has to bear that burden if those individuals are incapable of paying for it themselves. If they are one of those families of eight with a $250,000 income, we do not have to worry. But most of them are not. They are going to be moderate to low-income individuals who have no ability to pay for complex care themselves. The rest of the cost of that care, then, is going to be shifted onto other private payers in the form of premium increases or onto the public sector in the form of tax increases or deficit increases.

Senator DASCHLE. Thank you.

The CHAIRMAN. Thank you, Senator Daschle.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Dr. Reischauer, one point you made about the Breaux-Durenberger plan. You talk about the complexities of processing these applications for subsidies.

You indicate that that has a lot of difficulties to it. But have you not got the same problem in connection with the administration's plan? I am referring back to the booklet you presented us at the time you talked about subsidies for employers. But then, not only do you have the difficulty of working out the subsidies for the employers, but then you have the subsidy to the employee trying to make up the 20 percent.

So while I am not going to get into——

Dr. REISCHAUER. I do not think anything in our report on the administration's plan would suggest that we thought that it was simple.

Senator CHAFEE. No, I am not suggesting that. But you did in your testimony, it seemed to me on the Breaux plan, stress the complexities of the subsidy part. I just think you are probably

right. But the point is, you have the same difficulties in any of these plans, including the administration's plan.

Dr. REISCHAUER. And yours.

Senator CHAFEE. And ours. I admit that.

Dr. REISCHAUER. No, no, that is true. But remember that when the administration's plan came out, there was a lot of criticism about it being big government and intrusive.

Some of the other plans are being put forward as nongovernmental, nonregulatory, simpler alternatives. If they are being portrayed that way, it is the responsibility of the Congressional Budget Office to ask whether that is a correct characterization. That is why I mentioned it in this testimony.

Senator CHAFEE. Yes.

Dr. REISCHAUER. But I agree with you. Once you start providing individual subsidies, no matter how, you inevitably get into an extremely complex administrative system. Because what you are basically doing is calculating the equivalent of a welfare benefit but for a much larger fraction of the population.

Senator CHAFEE. But the purpose of my question really is to bring out the point that in the administration's plan you have a double difficulty. You have the difficulty of subsidizing the business. That has extreme complexities to it—how to do it and, indeed, how to prevent a gaming of the system because with the larger businesses you perhaps recall once they go over the threshold of I think it is 7.8 percent then there is no incentive at all for the business to——

The CHAIRMAN. 7.9 percent.

Senator CHAFEE. What is it?

Dr. REISCHAUER. It is 7.9 percent.

Senator CHAFEE. 7.9 percent. There is no incentive at all for the business to exercise any kind of restraints because after all the Federal Government is going to come up and pick it all up. That is just one part of it.

But the part that I confess that I had not thought about that much, but as I listen to you talk about the complexities of the individual subsidy under the Breaux plan, the same problems arise to some degree in the administration's plan where the individual is responsible for 20 percent.

A low income individual has to be subsidized for that also. Would you articulate your——

Dr. REISCHAUER. That is correct. The administration's subsidy scheme would be extremely complex and quite costly to administer. I am not suggesting for a minute that the Breaux-Durenberger system is more complex or more costly to administer than the administration's. We have not looked at that issue.

I think they are both quite complex relative to anything that the Federal Government is undertaking at this point.

Senator CHAFEE. Well, the purpose of my questions, Mr. Chairman, is to illustrate that each of these plans, is complex. And Dr. Reischauer in the Breaux plan went to some degree to point out those difficulties, less degree in the administration's plan for whatever reason.

But when you get to the subsidy, you have a double problem in the administration's plan. I think it is probably complexity built on

complexity when you are doing the business and the individual both, which some of us forget, and I must say I had overlooked that.

Dr. REISCHAUER. Let me just read a few sentences from our analysis of the President's plan that are often read to me. They are from a discussion of the regional alliances: "They would combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems, and coordinators of the flow of information and money between themselves and other alliances. They would also have to implement the controls on premiums under the direction of the National Health Board. Any one of these functions could be a major undertaking for an existing agency with some experience, let alone for a new agency that would have to perform them all.

Senator CHAFEE. That is a splendid sentence. [Laughter.]

What page are you on? I might underline it.

Dr. REISCHAUER. It is on page 70.

Senator CHAFEE. Page 70. Why did you put it way back there? [Laughter.]

Everybody is exhausted when they get to page——[Laughter.]

Well, thank you very much. If you have any other gems like that, let me know. [Laughter.]

Dr. REISCHAUER. Well, actually, we are saving them for the report on your bill. [Laughter.]

Senator CHAFEE. Well, I am not sure they will be applicable. [Laughter.]

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Chafee.

Just on this point, it is something government wants to be open about. Senator Daschle said, the Census undercount is a good estimate of what you can do. In 1940 with 150 years of experience, we reached the point where we covered 94.6 percent of the population.

Now in the last 50 years we have done much better and we are now down to where we cover more than 98 percent. But you never are perfect. That is all right.

Dr. REISCHAUER. But I would argue that there is no particular advantage for an individual in America to want to be counted in the census. I do not receive any particular benefit—except being a statistician, being somebody who loves the numbers, I like to participate in the census.

But health care is very different. What we are saying is that if you participate, you are going to get adequate health care coverage in America, and people should come forward.

The CHAIRMAN. Both points are true.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, let begin by saying, I share not only your optimism but your enthusiasm. If you watch this process from the outside, it is hard to believe we are going to get a consensus in the next few weeks. When you are on the inside, I think you have a right to be optimistic. I want everyone to know that I share that optimism with you.

Second, I want to say apropos of this exchange we just had that I read a column in Rhode Island newspaper, I think, yesterday in

Senator BRADLEY. Well, but this is just a basic question. Because it seems to me that, you know, before we head down the path of actually writing a piece of legislation that there ought to be numbers available that would accommodate any set of variations here. Not infinite, but a set of variations.

It in my mind, Mr. Chairman, just simply raises a question that I do not frankly know how we resolve. Maybe the administration can provide us with all the information, maybe they cannot, maybe we will have to wait for you. But at least it is a question.

Now, my second point. In the various exchanges here today, both between Senator Daschle, Senator Packwood and you, and Senator Moynihan was the issue of, well, how much will this get you in the way of coverage.

Will it be 91 percent or 95 percent or whatever? Whatever it will be, in your view it is less than the Clinton plan. Why?

Dr. REISCHAUER. Because there is neither an employer or an individual mandate.

Senator BRADLEY. All right.

Dr. REISCHAUER. Or a universal entitlement of the sort that the single payer plans would provide.

Senator BRADLEY. You also said that there was a shortfall that could be made up, and you said about 4 percent could be made up by you said an outreach to——

Dr. REISCHAUER. No, what I said is there are a number of——

Senator BRADLEY [continuing]. Adjustment of the subsidy. Now, what do you mean by that?

Dr. REISCHAUER. There are a number of individuals in our estimate who have incomes below the poverty level. Therefore, they would have available to them free insurance—basically, a complete subsidy. But they would not participate.

We made this assumption because we looked at the Food Stamp program, the Medicaid program and other programs, and we found that there were individuals who chose for one reason or another not to participate. We assumed that the same principle would hold true in the case of health care coverage. One reason that this is a program that, because of its voluntary nature, has to have specific periods during which you can apply to receive benefits.

Senator BRADLEY. Right.

Dr. REISCHAUER. You cannot just show up when you feel sick and say, "I want to buy insurance now." Applying is a complex process. Some people cannot get their act together and submit applications at the right time.

Senator BRADLEY. You need outreach and you need the adjustment subsidy?

Dr. REISCHAUER. Right.

Senator BRADLEY. Do you have any idea how much that would cost to get that additional 4 percent?

Dr. REISCHAUER. It is 4 million people, not 4 percent.

Senator BRADLEY. Four million additional people.

Dr. REISCHAUER. No, I do not. There is $10 million in the proposal as it stands now for those types of activities. But I think that is quite insufficient.

Senator BRADLEY. It is conceivable that States will not want to find these people on their uncompensated care budgets and will de-

vote sizable resources to try to enroll them. It seems to me that this is a number that would be important to have if you were going to propose a Breaux-Durenberger approach but were dissatisfied with 91 percent coverage: how much would it cost to add 4 million or 5 million more people?

Dr. REISCHAUER. Right.

Senator BRADLEY. So is that on your agenda to provide us with that number?

Dr. REISCHAUER. We have not been asked to until this moment.

Senator BRADLEY. All right.

The CHAIRMAN. Well, consider yourself invited.

Senator BRADLEY. Thank you, Mr. Chairman.

Dr. REISCHAUER. Where on the list of things we are doing should that go?

Senator BRADLEY. It is up to the Chairman.

Dr. REISCHAUER. Up to the top?

Senator BRADLEY. Now, in the exchange you had with Senator Durenberger he was making the point that you have not calculated the way medicine is practiced. You said indeed you had calculated the way medicine is practiced.

Dr. REISCHAUER. No, I would not claim that we had done that.

Senator BRADLEY. You have not?

Dr. REISCHAUER. What we have included in our assumption about savings resulting from the competitive environment that is created are obviously some changes in the way care will be provided. In part, that is what is going to bring down the costs.

Senator BRADLEY. But you also said that there was a difference in the welfare population and in early retirees, that under this plan——

Dr. REISCHAUER. That is, within the health plan purchasing cooperative pool of participants. That pool would look quite different from the Minnesota State employee pool.

Senator BRADLEY. And, therefore, they would be less susceptible to the voluntary nature of this. Is that the assumption?

Dr. REISCHAUER. No, they would be more expensive to cover.

Senator BRADLEY. More expensive to cover.

Dr. REISCHAUER. Because on average their health status would not be as good and their risks would be higher.

Senator BRADLEY. Now in the area of the premiums to cover the benefits.

Dr. REISCHAUER. Yes.

Senator BRADLEY. You estimate the premiums under the Breaux plan are higher than the premiums under the Clinton plan for basically identical benefits. Why are they higher under the Breaux-Durenberger than the Clinton plan when they are for identical benefits?

Dr. REISCHAUER. The administration's plan laid out a particular way of estimating initial premiums that excluded Medicaid recipients of cash benefits and included Medicaid recipients who did not receive cash assistance at the cost of providing their care. As you know, Medicaid provides reimbursements that are very, very low.

In this estimate, we included those Medicaid cash assistance recipients in our pool, which pushed the estimate up. For the Medicaid noncash recipients, we assumed that providers would be paid

at market rates rather than at the lower rates that are provided by Medicaid.

We also took account of the fact that the Breaux-Durenberger plan has quite generous subsidies for those below 200 percent of the poverty level, which would increase their utilization of services over and above what it is now. And that would push costs up.

We have to remember that this pool is a less healthy pool than the one formed under the administration's plan because this pool excludes all of the people who work for firms with over 100 employees. On page 18 of our report, we describe the various adjustments that we made and why the premium is higher under the Breaux-Durenberger plan than it would be under the administration's plan.

Senator BRADLEY. And then you estimated also the catastrophic package; is that true? So-called streamlined spartan package.

Dr. REISCHAUER. Are you asking, what are the premiums for that?

Senator BRADLEY. No, you estimated that. My question there is, how does the catastrophic package compare to what people currently receive in the market?

Dr. REISCHAUER. We believe that 90 percent of Americans with private insurance have a more generous plan now than that lower benefit package, which we estimated as having premiums 20 percent below the more comprehensive package.

The CHAIRMAN. Could I note that a vote has been called.

Senator BRADLEY. So 90 percent?

Dr. REISCHAUER. Ninety percent of those with private insurance have more generous coverage than that package would provide.

Senator BRADLEY. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Conrad, you are next and then Senator Riegle.

Senator CONRAD. Catch-22.

Dr. REISCHAUER. Are you walking away from this issue?

Senator CONRAD. I was going to exercise my right to vote.

Mr. Reischauer, some of us asserted that the Cooper plan would represent a middle class income tax increase. How would you react to that characterization after your review?

Dr. REISCHAUER. I would characterize it as a plan that makes Americans more sensitive to the full cost of the health insurance that they demand.

Senator CONRAD. And maybe you could go further and describe what you mean by that. I know your father was an Ambassador. That was very diplomatic.

Dr. REISCHAUER. Right now we provide substantial tax subsidies to all Americans who have employment-based health insurance. That subsidy has dulled their sensitivity to the full cost of the service that they are demanding, probably leading us to over-consume that service.

The Managed Competition Act, as well as a number of other proposals, attempts to redress that imbalance. These proposals say that for basic insurance, or insurance up to a society-determined level, people will receive tax-favored treatment and the tax subsidy will continue.

But those who want to purchase insurance or obtain insurance coverage that is more generous than what society regards as an adequate level should pay the full cost of that insurance and not receive a tax advantage for it. Therefore, for those individuals, there would be an increase in their taxes.

Senator CONRAD. This is the structure that makes them more sensitive to the full cost of their health care.

Dr. REISCHAUER. Yes.

Senator CONRAD. What is the result?

Dr. REISCHAUER. The result depends very much on which particular benefit package you select.

Senator CONRAD. Let us say it is comprehensive.

Dr. REISCHAUER. If you select the comprehensive one, there is, in fact, very little in the way of additional tax burden placed on Americans because that package is similar in costs or, indeed, a little more generous than what they receive right now.

In fact, for many Americans, this plan would do just the opposite of what your question implied because for the first time it would allow self-employed individuals and those who do not have employment-based insurance to fully deduct their premium payments up to the basic premium level. And for those who work for an employer who puts in, perhaps, only 50 percent of the cost of the basic package, the 50 percent that was paid for by the individual, up to that reference premium amount, would also be deductible.

So, in fact, under the comprehensive package in our estimate, there is a loss of tax revenue. In other words, on average, it is a tax break. And it is only when you ratchet back the generosity of the plan substantially that that situation turns around.

Senator CONRAD. The offset to that is, or the other side of the coin, I presume, is that it increases the subsidy amount.

Dr. REISCHAUER. Yes, the plan does, very much.

Senator CONRAD. Yes. Could you characterize that?

Dr. REISCHAUER. You mean the subsidies for low—income individuals?

Senator CONRAD. What happens to this total subsidy amount for low-income individuals?

Dr. REISCHAUER. I am not sure of the context in which that question is being asked. When the benefit package is ratcheted back?

Senator CONRAD. When the benefit package is ratcheted back?

Dr. REISCHAUER. The premium subsidies for individuals decline, but they decline in conjunction with the reduction in the premium. So if you were a person at the poverty level under a basic benefit package, you would still receive a full subsidy for your health care.

Senator CONRAD. What is the total amount of this subsidy if you take the comprehensive benefits package versus the slimmed down spartan benefits package in your analysis?

Dr. REISCHAUER. Well, those figures are given on pages 22 and 23 of our report. I would have to add up a whole column of numbers here to get them. The comprehensive benefit package in the year 2004 would have subsidies of $277 billion. The less comprehensive package would have subsidies of $240 billion.

Senator CONRAD. Can you tell us what the Clinton plan subsidy costs would be in the same year?

Dr. REISCHAUER. I could provide that for the record, but I do not have that information with me.

Senator CONRAD. All right. I would be interested in what that comparison would be.

[The following was subsequently received for the record:]

SUBSIDY COSTS IN THE ADMINISTRATION'S PROPOSAL

Under the Administration's health proposal, federal subsidies for employers and for families would total an estimated $197 billion in 2004.

The CHAIRMAN. Thank you very much, Senator Conrad. The committee is going to have to stand in recess for about 10 minutes.

Senator Riegle, would you like to take over here?

Senator RIEGLE. Please, and I will take my chances on the vote.

The CHAIRMAN. You recess the committee when you can and we will be back and it will come to a conclusion. You have been wonderful.

Senator RIEGLE. Thank you, Mr. Chairman.

Let me just say that a small business benefit study that was recently completed at the University of Michigan School on Public Health shows that many small businesses, even with subsidies and access to purchasing cooperatives still may not offer benefits to their employees under a voluntary system. That is one of the problems we face.

The study found that 61 percent of small businesses without health insurance were simply not interested in offering health benefits to employees. And reasons for this varied. In some cases employers thought employees could get coverage from other sources, perhaps through their spouse with another job.

These findings seem consistent with your analysis which shows that between 24 to 26 million people would be uninsured even after 10 years under the Managed Competition Act. Am I correct?

Dr. REISCHAUER. Yes, you are. Under the incentives that are established by the Managed Competition Act, I think that if you were a small business with a low-wage work force—a hot dog stand or something like that—it would be irrational for you and your employees to contribute to health insurance coverage.

Senator RIEGLE. That is the problem.

Dr. REISCHAUER. Because all you would be doing is reducing the subsidy amount that the government paid and the take-home wages of the individual workers.

Senator RIEGLE. So the only way to really get around that is by assuring universal coverage, some kind of a mandate. Somebody has to be mandated to do this or you are not going to fill in that gap; is that not correct?

Dr. REISCHAUER. Yes, or some kind of universal provision as in a single-payer plan. But I do not want to sound as though I am an advocate of a single-payer plan.

Senator RIEGLE. That in a sense is the same thing in a different form.

Well, I am going to give you some additional questions for the record on this.

[The questions and responses appear in the appendix.]

Senator RIEGLE. I am struck by the fact that you end up with a big gap in coverage and still result in a 10-year deficit shortfall

of about $300 billion. That is a pretty heavy finding that you have reached here and I think you have done it objectively.

If you will answer my additional questions for the record, I will be most appreciative.

Dr. REISCHAUER. I would be glad to.

Senator RIEGLE. The committee will stand in recess now for 10 minutes until the Chairman returns.

[Whereupon, at 12:17 p.m., the hearing recessed and resumed at 12:31 p.m.]

The CHAIRMAN. Our alert Secretary is recording there as ever. We almost had a seventh inning stretch, but I do not think it is the seventh inning. It is more like the last of the ninth, to give you some hope there.

Dr. REISCHAUER. Well, I will behave in such a way that we will not have to go into extra innings.

The CHAIRMAN. Let us see, I think, Senator Baucus, you are next.

Senator BAUCUS. Thank you, Mr. Chairman.

The CHAIRMAN. All right, sir.

Senator BAUCUS. Dr. Reischauer, I would like to turn to page 22 of your report. If I understand your report correctly, it concludes that under this bill, the analysis of this bill concludes that there will be a 40 percent reduction in uninsured, but that subsidies would be short by about $301 billion.

Dr. REISCHAUER. That shortfall occurs only under the comprehensive benefit package. Under the less comprehensive package, there would be no shortfall for all practical purposes, and we would expect roughly the same number of people to be added to the rolls of the insured. In other words, there would be a 40-percent reduction of the uninsured population under a plan for which there would be relatively——

Senator BAUCUS. A 40-percent reduction under both?

Dr. REISCHAUER. Yes.

Senator BAUCUS. All right. But this analysis on page 22 basically assumes the Clinton benefits package; is that correct?

Dr. REISCHAUER. That is correct.

Senator BAUCUS. And so if we have a benefits package which is by in large similar to the benefits package in the President's plan which is essentially the benefits package I think most people are generally talking about, you are concluding that the total deficit with full subsidies result in about $300 billion by the year 2004. So it would be a shortfall of about $300 billion?

Dr. REISCHAUER. Over the course of that 9-year period. The deficit in a single year would be smaller.

Senator BAUCUS. Right. I think that is an important point for people to realize. I think some place early in your report you mention—I do not have it in front of me right now—that you feel that the limitation on subsidies probably will not be politically viable and Congress is probably going to have to come up with a subsidy somewhere. Here it is. It is on page 39.

Basically on page 39 you said, "Although a Federal liability for a subsidy will be effectively capped, CBO believes that if the shortfall of subsidies were substantial, the mechanism for limiting the

Federal subsidies would seriously disrupt the insurance marketplace and would render it unworkable."

So it is sort of a Hobson's choice as CBO sees it. Either the caps work which renders the insurance marketplace unworkable or we have to come up with a little creativity.

Dr. REISCHAUER. I think all of this is a little unfair because the architects of this bill did not realize how the numbers were going to turn out. They have said quite publicly in the last couple of days that their response to this situation would be to look for additional savings or revenue increases or to scale back these subsidies in such a way as to avoid creating that kind of a disruption.

Senator BAUCUS. That is right. So the alternatives, therefore, are to try to cut back benefits substantially or raise revenue substantially or cut expenditures some place else substantially. But still the framework concludes a $300 billion shortfall unless you raise taxes, or you cut benefits substantially, or we cut the whole program substantially some place else.

Thank you.

Dr. REISCHAUER. Correct.

The CHAIRMAN. Thank you, Senator Baucus.

And now a final exchange with Senator Breaux and Dr. Reischauer.

Senator BREAUX. Well, I just want to make a point. The point that Max is making is absolutely correct. I mean, you can either do one of those and make up the difference or you can do a combination of a little fall of those suggested avenues in making up the difference and get back to the point where we thought we were after we got the last estimate in CBO in 1993.

I think Dr. Reischauer has correctly pointed out the fact that we are operating at a little bit of a disadvantage in trying to put it together.

The point I want to make now though is, and I am just concerned that we are going to end up being prisoners of ourselves or prisoners of ourselves and CBO. In the sense that we get plans scored last year, we respond to those scoring by making changes, which are then resubmitted and rescored with different results.

Therefore, we now have to go back and redraft a bill in order to have it once again rescored. But we are still yet waiting for the scoring on major plans that are pending before this committee like the Chafee bill and like others that are pending before the Congress and the United States.

I am concerned that we are not going to be able to do it all this year. I think that what we are looking at is trying to do it one step at a time, which I have always felt was the best way to do it. I am coming to the conclusion that it may be the only way that we can do it because of what we are facing with regard to these packages being scored and presented as we are sitting here in May. But still some of the major plans, with no fault of theirs, just has not been scored so that we could act.

Then if we do a committee draft, Mr. Chairman, does it not also have to be submitted for scoring purposes before we can go to the floor? Which is another step in this process that has to be completed if we try and do it all.

Therefore, I think that the argument for doing it one step at a time and maybe not doing everything is becoming not only more and more feasible, but more and more likely as well. So I thank CBO for their work. I mean, you are under a tremendous amount of pressure to get these things done very quickly, not to mention you are doing other things as well.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

May I just say that that was a perfectly reasonable assessment of our situation. But there are members of the committee, of which I am one, who mean to get a bill done this year. There are some Senators who are leaving the committee and very much want the bill this year, including your co-sponsor.

Senator BREAUX. I would just say, Mr. Chairman, I think we should do a bill this year. It is just a question of the size of the bill and do we have to do it all in this year or can we do it by steps.

The CHAIRMAN. Sir?

Senator BREAUX. Mr. Chairman, I wonder half facetiously if we can use the services of the Joint Tax staff to help score this. I know that many times the committee to get out tax bills have to go back and rescore and get estimates and I know the CBO is doing a very good job.

Dr. REISCHAUER. The Joint Committee on Taxation participates in these analyses with us. They do all of the revenue estimates. They are finding this work as complicated and as difficult as we are.

The CHAIRMAN. And properly and professionally. You do it very well. This is to thank you once again, not, I fear, for the last time.

Everybody in that first row can take a 45-minute lunch break. That is how our grateful government treats its most loyal employees. Thank you all again very much.

Dr. REISCHAUER. Thank you.

[Whereupon, at 12:40 p.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted

Prepared Statement of Robert D. Reischauer

Mr. Chairman, at the request of your Committee and others, the Congressional Budget Office (CBO) has prepared an analysis of the Managed Competition Act of 1993. We are releasing our study today, in conjunction with this hearing, and my testimony will summarize the study's findings.

My statement provides an overview of the proposal, identifies the key features of the managed competition approach to health reform, and considers the effects of the proposal on national health expenditures, the federal budget, and the economy. The statement concludes with an examination of the problems that would arise if the funding designated in the proposal for subsidies for low-income people were insufficient to pay the subsidies in full.

OVERVIEW OF THE PROPOSAL

The Managed Competition Act of 1993 endeavors to slow the growth of health care costs and expand access to health insurance by strengthening competitive forces in health care markets and providing people with better access to affordable coverage. It would restructure health insurance markets, provide people with strong incentives to purchase health insurance prudently, and subsidize health insurance for low-income people.

The proposal would make health insurance available to all but would not establish universal coverage. Individuals would not have to obtain coverage if they did not choose to do so, and employers would only have to offer—not pay for—coverage for their workers. Even without individual or employer mandates, the number of uninsured people would drop significantly under the proposal.

The major vehicle for reorganizing the health care marketplace would be regional health plan purchasing cooperatives (HPPCs). Through them, employees of small firms (generally those with 100 or fewer employees) and individuals with no attachment to the labor force would purchase coverage. (Medicare's coverage would, however, be essentially unchanged.) The HPPC would offer those people a choice of accountable health plans (AHPs), which would provide a standard benefit package. AHPs would have to meet strict requirements regarding open enrollment, limits on exclusions for preexisting conditions, and modified community rating—allowing each AHP's premiums to vary only by age and the type of enrollment (individual, individual and spouse, individual and one child, and individual and family).

Firms with more than 100 employees would also have to offer their employees the opportunity to purchase coverage from an AHP. They could accomplish this either by self-insuring—that is, setting up their own AHPs—or by purchasing coverage from an AHP offered in the non-HPPC marketplace. They could not participate in a HPPC, however, unless they were located in states that took advantage of the option to raise the maximum size of firms that must participate in a HPPC.

The proposal would make changes in the tax code, some of which would promote more widespread insurance coverage while others would discourage the purchase of generous policies. Premiums paid to AHPs would be tax deductible up to the "reference premium"—that is, the premium for the lowest-cost plan offered through the HPPC that covered at least a specified proportion of eligible enrollees. The deduction would encourage people to purchase health insurance: under current law, the self-employed and people purchasing individual policies generally do not qualify for tax subsidies. Because premiums in excess of the reference premium would not be deductible, employers would be encouraged to limit their contributions for health insurance premiums, and consumers motivated to select lower-cost health plans.

Under the proposal, the Medicaid program would end, and a broad system of federal subsidies would enable low-income people to purchase acute care coverage from AHPs. States would assume responsibility for the long-term care component of Medicaid, with most of them benefiting from the new division of responsibilities with the federal government.

Subsidies for premiums and cost sharing would be available for everyone with income below 200 percent of the poverty level. (The only exceptions would be Medicare beneficiaries for whom subsidies would mirror current Medicaid benefits for dually eligible enrollees and "qualified Medicare beneficiaries.") Those at or below 100 percent of the poverty level would be fully subsidized for the reference premium. The premium subsidies would be phased out between 100 percent and 200 percent of the poverty level. By contrast, the subsidies for cost sharing would be the same throughout the entire income range up to 200 percent of the poverty level; no one in this group would have to pay more than nominal cost-sharing amounts. Individuals with income below 100 percent of the poverty level would also be eligible to receive a package of wraparound benefits—additional benefits that would not be part of the standard benefit package.

Spending on the subsidies would be limited to the amounts generated by proposed reductions in current health care programs, revenue changes, and prefunding of retiree health benefits for the Postal Service. Low-income participants would not be required to pay more if insufficient funds were available to fund the subsidies fully; rather, AHPs would have to absorb the shortfalls.

A new federal agency, the Health Care Standards Commission, would oversee the health care system and design the uniform benefit package. It would establish broad principles and standards for the system and would also undertake such day-to-day activities as determining eligibility for subsidies and registering AHPs. The commission's responsibilities would be far-reaching and would generally transcend those of state and local governments in the health care arena.

MANAGED COMPETITION

The managed competition approach, which provides the basis for this proposal, remains largely untried. Advocates of the approach believe it has the potential to slow the rate of growth of health spending, but estimates of the magnitude of such effects are highly speculative. When CBO examined this issue in a 1993 study, it concluded that the capacity of any particular managed competition proposal to control costs would depend on the degree to which it included the following eight features:

- Regional purchasing cooperatives that would oversee a restructured health insurance market;
- Universal access to health insurance with community rating of premiums and limited restrictions on coverage;
- Universal health insurance coverage;
- A standard package of benefits for all health plans;
- Comparative information on the price and the quality of all health plans;
- Health plans with almost no overlap in their networks of providers;
- Effective mechanisms to adjust the premiums paid to health plans for the health risks of their enrollees; and
- Limits on the amount of health insurance premiums that people could shelter from taxes set at the cost of the least expensive plan.

The Managed Competition Act includes all or part of seven of these features. It would not, however, require universal coverage, even though the number of uninsured people would certainly fall. Whether an effective risk-adjustment mechanism could be developed is uncertain, but that problem besets many health care proposals—not this one alone. The proposal would also be in closer accord with the eight conditions if all of the population had to purchase health insurance through HPPCs and if HPPCs were given more power to negotiate with health plans.

CBO believes that the proposal incorporates the key attributes of managed competition sufficiently well that—over time—significant savings would result from both the more competitive market environment and the enrollment of more people in effectively managed plans. The magnitude of these savings, however, remains largely a matter of speculation. Presumably, the effect on the growth rate of national health expenditures (N HE) would depend on the benefits included in the standard package. The more comprehensive the package, the larger the proportion of NHE that would be under the managed competition system and, hence, subject to its cost-reducing incentives. For the purpose of its cost estimates, CBO assumed that increasing enrollment in effectively managed plans would slow the growth in costs of AHPs by 0.6 percentage point per year for the first five years. In addition, competitive forces would dampen the rate of growth of costs of AHPs by increasing amounts

over the projection period, thereby reducing the annual rate of growth by 1 percentage point after 2004.

FINANCIAL IMPACT OF THE PROPOSAL

As with other proposals to restructure the health care system fundamentally, estimates of the effects of this proposal on national health expenditures and on the federal budget are highly uncertain. In addition to the lack of evidence about the effects of managed competition per se, the proposal leaves many important details—such as the standard benefit package—unspecified.

In preparing its cost estimates, therefore, CBO had to make a number of assumptions about the effectiveness of managed competition and the unspecified dimensions of the proposal. The estimates are extremely sensitive to these assumptions, the most important of which relate to the standard benefit package. In general, a more comprehensive benefit package would result in a higher premium, which would—in turn—translate into higher budgetary costs and national health expenditures. Although a more limited benefit package would have a lower premium, it would probably have little effect on the number of people with insurance. More limited standard benefits would, however, raise the after-tax costs of insurance for people who currently have more comprehensive policies, many of whom would probably purchase supplementary coverage out of after-tax income. As a result, they would probably become more prudent purchasers of health insurance.

Because of the uncertainty regarding the benefit package, CBO estimated the financial effects of the proposal under two illustrative alternatives. The first is the comprehensive benefit package proposed in the Administration's Health Security Act. The second is a benefit package costing 20 percent less than the first; it would have limited hospital coverage and would not cover prescription drugs, dental care, mental health, and preventive services. CBO concluded that, for differing reasons, neither alternative would be feasible without further adjustments to the proposal.

Under the more comprehensive alternative, the number of uninsured people would drop by almost 40 percent in 1996 (from 39 million to 24 million), with less than 10 percent of the population remaining uninsured thereafter. National health expenditures would rise above CBO's baseline initially—reflecting the increase in the number of people with insurance—but would fall below the baseline once the effects of managed competition, more enrollment in managed care, and cuts in the Medicare program began to be felt. By 2004, NHE would be $30 billion (or about 1½ percent) below the baseline.

Under this alternative, spending on subsidies would far exceed the funds designated for them; between 1996 and 2000, the average annual shortfall would be over 30 percent of the subsidies for premiums for non-Medicare enrollees. Although the proposal would require health plans to absorb shortfalls in subsidies, shortfalls of that magnitude could cause turmoil in HPPC markets. To avoid that possibility, the subsidies would have to be close to or fully funded. Consequently, some other features of the proposal would have to change if one wished to maintain a comprehensive benefit package. Possible options include reducing the generosity of the subsidies or augmenting the pool of resources available to fund the subsidies by cutting other programs, raising taxes, or allowing the budget deficit to increase.

Under the less comprehensive benefit package, the number of uninsured people would be about the same as under the first alternative. As before, national health expenditures would rise in the early years—but by less than under the comprehensive alternative—and then fall below CBO's baseline.

Even though the premium would be 20 percent lower under the second alternative, the resources available under the proposal would be insufficient to fund the premium subsidies fully. Rather than cut back the already Spartan benefit package further, CBO chose to modify the proposal's subsidy scheme to permit full funding of the subsidies without exceeding the funds available in the subsidy pool. For the purposes of this illustration, CBO assumed that the cost-sharing subsidies for people with income between 100 percent and 200 percent of the poverty level would be dropped. With that additional assumption, the subsidies would be funded in full or nearly so after 1997.

EFFECTS OF THE PROPOSAL ON THE ECONOMY

By ensuring that people could purchase health insurance at community rates regardless of their health status, the proposed restructuring of the health insurance market would improve certain aspects of labor markets. For example, it would assure workers who have health insurance through their jobs that they could continue to obtain coverage if they changed jobs or left the labor force. Insofar as some workers hesitate to change jobs because of the possibility of losing their health insurance,

the problem of "job lock" would be reduced. Moreover, some workers might choose to retire early if they knew they could still obtain health insurance.

The subsidies for premiums and cost sharing would greatly reduce the number of people without coverage and would be very beneficial for low-income workers. But such workers would receive the full benefit of the proposed subsidy system only if their employers did not pay for insurance and, consequently, low-income workers would have incentives to work for employers that did not pay for insurance. If the employer of a low-wage worker contributed some amount toward insurance coverage, the subsidy would be reduced dollar for dollar under the proposal. In addition, the worker's wage would be lower than it would be if the employer did not contribute because employers shift the costs of such contributions back onto workers through reduced cash wages.

These effects would be particularly pronounced for workers with employment-based insurance and income close to the poverty level; they could earn considerably more if their employers no longer paid for coverage and subsidies would pay for most of their health insurance. By contrast, higher-income workers, who would not be eligible for subsidies, would probably prefer that their employers pay for insurance rather than pay them higher cash wages in order to avoid the payroll taxes they would pay on higher wages.

A less desirable consequence of the proposed system of subsidies is that it could discourage some people with incomes between 100 percent and 200 percent of the poverty level from working more. People with income in the range in which the subsidies were phased out would have to pay more for health insurance as their income rose. Some workers in this income range already face high effective marginal tax rates because of the phaseout of the earned income tax credit and the payment of income and payroll taxes. The phaseout of the subsidies for premiums would impose an additional marginal levy on workers of 15 percentage points to 30 percentage points, depending on their family type and the comprehensiveness of the benefit package.

Low-income families would also lose valuable benefits abruptly if their income rose to the point at which they lost eligibility for cost-sharing subsidies. (That income level would be 200 percent of poverty under the proposal as written, or 100 percent of poverty under CBO's second alternative with limited benefits.) Since there would be no graduated phaseout of those subsidies, a large "cliff" effect would result: below the income cutoff, people would have full cost-sharing benefits—worth an average of approximately $1,400 for a family of four in 1995—and above that income level they would not have any. A similar "cliff" would occur when people's income reached 1 percent of the poverty level and they lost their eligibility for wraparound benefits. The amount they would lose would depend on the benefits covered by the standard benefit package—the more generous the coverage the less would be included in the wraparound benefits. Thus, under the comprehensive benefit package, the wraparound benefits would be worth an average of $600 for a family of four in 1995; under the less generous alternative, they would be worth $2,900.

The problem of high effective marginal tax rates for people affected by the phaseout of subsidies is not unique to this proposal. Unfortunately, alternative solutions—such as reducing subsidies or phasing them out over a wider income range—would generate other problems. Smaller subsidies would require low-income people to pay a higher percentage of their health care costs; a slower phaseout would increase federal subsidy payments and cause workers at higher income levels to face disincentives for additional work.

HOW SHORTFALLS IN PAYMENTS WOULD AFFECT AHPS AND INSURANCE MARKETS

Certain features of the proposal might produce unintended consequences, lengthen the time needed for implementation, or limit the effectiveness of the proposal. Some of those features could be modified quite easily. Modifying others might prove more difficult.

One particularly problematic feature of the proposal is the large shortfalls that could face AHPs. If the funding designated for subsidies was insufficient to pay them in full, the federal government would reduce the proportion of the premium subsidies it paid and the AHPs would have to absorb the difference. They could not require low-income enrollees to pay more.

Shortfalls in premiums paid to health plans could also occur with full funding of the federal subsidies because the maximum federal subsidy could not exceed the reference premium for the HPPC. Low-income enrollees who chose AHPs with premiums higher than that amount would have to pay only a portion of the difference; the plans would have to absorb the shortfall. Some plans might also experience

shortfalls in subsidies for cost sharing because those payments would not be related to the actual use of services by a plan's low-income enrollees.

To ensure that shortfalls in payments would not disproportionately affect AHPs enrolling large numbers of low-income people, the proposal would establish an interplan reconciliation process for low-income assistance. The scheme would require all AHPs, including self-insured plans, to participate in a nationwide system to distribute shortfalls in premiums and cost sharing equitably among health plans. This process would be extremely complicated; its feasibility is doubtful. Yet, without an effective mechanism, premiums in the HPPC could be highly unstable.

Instability of premiums would be a consequence of both the uncertainty plans would face in setting premiums and their probable responses to shortfalls. Although health plans could adapt to some uncertainties, as they do today, the proposed approach for shifting shortfalls in payments to plans would require them to deal concurrently with many unknown, interdependent variables in determining their premiums. As a result, the process would be exceptionally difficult. Moreover, there would be no guarantee that the uncertainties would lessen over time.

AHPs could respond to shortfalls in payments in various ways. But the responses and their impacts would generally be greater within HPPCs than outside them because low-income people would constitute a much higher proportion of the HPPC population. In the short term, AHPs might lower payments to providers or reduce the quantity or quality of the services they provided. In the longer term—when AHPs had the opportunity to do so—they would almost certainly raise their premiums. Plans facing strong competitive pressures might withdraw from the market altogether.

Because enrollment in AHPs would be voluntary, some people whose premiums were not heavily subsidized might drop their insurance coverage if premiums rose significantly. Healthy people who felt the least need for coverage would be the most likely to withdraw in those circumstances. The loss of healthier people would cause the average risk level of enrollees in the HPPC to rise, placing further upward pressure on premiums. An upward spiral of premiums in the HPPC might result.

In the absence of an effective distribution process, extremely high shortfalls in payments could rapidly undermine insurance markets. For example, under the comprehensive benefit package assumed in CBO's first alternative, the shortfalls in premium subsidies would be so large that the HPPC system might collapse if AHPs had to absorb them.

CONCLUSION

The Managed Competition Act would significantly reduce the number of people lacking health insurance, but—because key elements of the proposal are unspecified—its effects on the budget, the economy, and health insurance markets are uncertain. Although several features of the proposal as written might impair its effectiveness or prove difficult to implement, the majority of them could probably be addressed quite easily through minor modifications.

More controversial are those elements of the proposal that both reflect its underlying philosophy and might also limit its feasibility. For example, allowing enrollment in AHPs to be voluntary and restricting the size of firms that could participate in the HPPC would have the potential to produce unstable premiums—especially if the federal subsidies were not fully funded. Moreover, without additional revenues or spending cuts, deficit neutrality would be difficult to reconcile with a comprehensive benefit package and full funding of the subsidies.

Such problems present difficult choices and trade-offs. The most immediate question, however, concerns the issues that should be left to the Health Care Standards Commission, other government agencies, or the Congress to decide in the future.

Responses of Mr. Reischauer to Questions From Senator Rockefeller

ESTIMATES OF TAX CAP

The Joint Committee on Taxation (JCT) has provided the following response.

Question. The structure of the Breaux bill (and the Chafee bill which also has a tax cap) establishes the cap on a region by region basis. I understand that most estimates of the revenue yield of a tax cap have been done on national distributions of health care costs. Yet there is much in three of the bills before us that will reduce this variation in the future. Breaux, Chafee, and Clinton all require a standardized benefit package and some form of community rating. In addition, Breaux and Chafee, which both have tax caps, set the cap community-rating area by community-rating area. Thus there may be as many as 200 area caps. Setting caps area by area is likely to reduce health care cost variation that results from differences in input

prices and from differences in medical practice styles as well as from standardization of benefits and community-rating. Finally, the statistical variance in health care costs in 200 local areas will be significantly lower than the statistical variance in a national distribution. This occurs whenever a single distribution is broken into several sub-distributions with different means and standard deviations. My staff tell me that the reduction in variance from this factor alone might reduce the estimated revenue yield from a national tax cap by over 50 percent.

Has the JCT used the national distribution of health care costs in developing its estimates of the revenue yield from a tax cap?

Answer. Yes, the distributions of health care expenditures that JCT and others use are based on national samples which provide estimates of national distributions of expenditures.

Question. Has the JCT made any adjustment for the fact that in the Breaux bill (and later the Chafee bill) tax caps will be set community-rating area by community-rating area? Based on statistical theory alone, how large a reduction in the national variance would JCT attribute to this premium setting structure?

Answer. No, we did not make such an adjustment. Statistical theory is ambiguous about the size of the variance of a part relative to the variance of a sum. The variation of premiums within a region could very easily be larger than the variation of premiums in the nation as a whole. Only in the case where expenditures on health care in one region are independent of expenditures (premiums) on health care in any other region can it be maintained unequivocally that regional variation in expenditures would be less than the national variation in expenditures. In general, however, there are significant components of health care costs that are common across regions, making this assumption untenable.

Question. If the JCT has not made such an adjustment, would JCT believe that such an adjustment is warranted?

Answer. The JCT does not believe that such an adjustment is necessary. We analyzed the potential effects of variation in the tax caps among HPPCs and determined that such variation would have a minimal effect on the revenue estimates for the Cooper and Breaux bills.

Question. If so, how large an adjustment would JCT make?

Answer. At the most we would adjust our estimate of the income and FICA tax effect of changes in taxable wages of workers who currently have employer-sponsored health insurance downward by 3 percent to account for the effect of regional variation.

Question. Are there any additional adjustments that JCT believes might be warranted based on the reduction in premium variance from standardizing benefit packages and from community-rating itself?

Answer. Because it is not at all! clear that the variation in premiums will be reduced at the regional level, we have not considered any further adjustments.

Question. Has the JCT taken into account that there will be only one plan in many areas of the country that can't sustain multiple plans and that in others there may be only two plans, but with little price competition? What difference would this make to the estimates?

Answer. Given our revenue estimating approach, the relevant distribution of employer contributions to health insurance premiums was the present-law distribution.

Responses of Mr. Reischauer to Questions From Senator Riegle

Limiting Employer Tax Deductibility of Benefits

Question. In previous testimony before this Committee it was stated that the impact of limiting employer deductibility will be felt by employees in the form of reduced benefits or added costs. Specifically, employers may respond to a tax cap by lowering benefits and passing the savings to the employee. However, this savings will not make up for lost benefits. Or employers may be absorbing the cost of nontaxable benefits and passing the added cost on to the employee.

What percentage of Americans who are insured have benefits better than the limited benefits model you described?

Answer. The limited benefit package would be less generous than that enjoyed by 90 percent of people with private health insurance coverage.

Question. What impact would limiting employer tax deductibility to this low level benefits package have on the average worker in an average priced plan today?

Answer. Average workers would pay more taxes because their current health insurance premiums would exceed the cap. Taxes would go up directly as well if the employer cut its health insurance contribution and increased cash compensation. In that case, however, workers would be at least partially compensated for the reduc-

tion in coverage by an increase in wages. If, instead, the employer continued to contribute the same amount toward employees' health insurance, the employer would be liable for the excise tax, which would be passed on to workers in the form of lower wages.

Question. Is it possible that he could be faced with less coverage, higher costs or both?

Answer. Yes.

COVERAGE AND COST SHIFTING

Question. Your analysis of the Managed Competition Act states that between 24 and 26 million people will remain without health insurance. Therefore, cost shifting, where the cost of uncompensated care is shifted to private payers, will continue. What effect will this have on the health care system?

For example, certain hospitals and providers will have to provide a disproportionate share of uncompensated care, making them less competitive. With increased competition, those that remain uninsured will find it even harder to find care. They may become sicker before seeking care. How can you have competition when uncompensated care is spread unevenly among providers and health plans?

Answer. The Managed Competition Act would probably reduce the amount of uncompensated care that hospitals now provide, since more low-income people would have insurance coverage. Nonetheless, uncompensated care would continue to be a problem in some health care markets and could make it difficult for "safety net" providers to compete in those markets.

Several provisions of the proposal would provide additional support for providers who serve low-income people. For example, health plan purchasing cooperatives could require accountable health plans to serve urban and rural underserved areas, and funding would be available to promote the development of AHPs in such areas. Additional funds would be authorized for community and migrant health centers, transitional assistance for safety net hospitals, and the National Health Service Corps. The proposal would also increase authorizations for several Public Health Service programs.

SMALL BUSINESSES

Question. What percentage of small businesses who do not currently offer insurance will do so under the Managed Competition Act?

Answer. Under the Managed Competition Act, all firms—regardless of their size—would have to offer health insurance to their employees. They would not, however, be required to contribute to that coverage.

NATIONAL HEALTH EXPENDITURES

Question. I want to make sure I understand the differences between the Clinton plan and this plan in terms of National Health Expenditures over a 10 year period (1995–2004).

The Breaux-Durenberger plan estimates are based on a limited benefit package and a more comprehensive benefit plan. Under these two benefit models (according to page 21 of CBO's analysis), the Managed Competition Act

- costs $31 billion over 10 years for comprehensive benefit plan, but 26 million are uninsured;
- saves $139 billion over 10 years with limited benefit plan. But many people may go without needed services.

In February, CBO estimated the Clinton plan. According to page 26 of that analysis, Clinton's plan saves $337 billion over 10 years for a comprehensive benefit plan and everyone is covered.

Is this an accurate assessment?

Answer. The figures that you cite reflect cumulative changes in national health expenditures over the 1996–2004 period. Over that period, the limits on the growth of health insurance premiums contained in the Clinton Administration's proposal could substantially reduce the rate of growth of health spending.

Our analysis of the Administration's proposal, however, observed that the full effects of limiting the rate of growth of premiums would be highly uncertain. Some experts believe that the Administration's targets for premiums could be largely met by increasing the efficiency of the health care system. Others maintain that tight constraints could have. undesirable effects on the health care system and might prove to be politically untenable.

OVERVIEW AND ESTIMATED REVENUE EFFECTS OF THE MANAGED COMPETITION ACT OF 1993 (H.R. 3222 AND S. 1579)

Prepared by the Staff

of the

JOINT COMMITTEE ON TAXATION

May 6, 1994

JCX-7-94

INTRODUCTION

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides an overview and estimated revenue effects of H.R. 3222 and S. 1579, the "Managed Competition Act of 1993". H.R. 3222 was introduced by Mr. Cooper and others on October 6, 1993; and S. 1579 was introduced by Sen. Breaux and others on October 21, 1993.

Part I of the document is a brief overview of the bill; and Part II shows the estimated revenue effects of the tax provisions of the bill under two possible benefit packages.

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[1] This document may be cited as follows: Joint Committee on Taxation: Overview and Estimated Revenue Effects of the Managed Competition Act of 1993 (H.R. 3222 and S. 1579) (JCX-7-94), May 6, 1994.

I. OVERVIEW OF THE MANAGED COMPETITION ACT OF 1993 (H.R. 3222 AND S. 1579)

A. In General

The Managed Competition Act of 1993 (H.R. 3222/S. 1579, "the bill") has as its stated goal "[t]o contain health care costs and improve access to health care through accountable health plans and managed competition." The bill would not require individuals to purchase health insurance nor employers to pay any portion of their employees' health care costs. It would require employers to provide employees the opportunity to acquire health insurance--in the case of small employers by participating in state-sponsored health plan purchasing cooperatives (HPPCs). The sponsors of the legislation contend that the availability of HPPCs together with a number of tax incentives and disincentives contained in the bill will increase price competition among health plans and providers, thereby reducing prices and making health care coverage available to more individuals. The bill would provide health-care subsidies to low- income individuals through premium and cost sharing assistance.

The bill would establish a Health Care Standards Commission (the "Commission") to implement various requirements under the bill.[2]

B. Health Plan Purchasing Cooperatives (HPPCs)

The bill would provide opportunities and incentives for eligible individuals and small businesses to purchase health care coverage through HPPCs. HPPCs would negotiate with accountable health plans (AHPs); enroll individuals in AHPs, charge, receive, and forward premiums; reconcile low-income assistance; coordinate with other HPPCs; and establish a complaint process. Each State would be required to establish HPPCs by July 1, 1994.

In general, all individuals other than full-time employees of large employers could purchase coverage through a HPPC.[3] Members of the same family would not be required to enroll in the same AHP. Thus, members of the same family could enroll on an individual basis in different AHPs offered by a HPPC.

C. Employer Obligations

Small employers would be required to enter into agreements

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[2] S. 1579 calls the entity that would perform these duties the National Health Care Board rather than the Commission.

[3] A large employer generally would be one with more than 100 employees.

with HPPCs to facilitate the purchase of health coverage by employees through the HPPC. Small employers would be required to provide certain information to the HPPC with respect to those employees who purchase insurance through the HPPC, to deduct from employees' compensation the premium due, and to forward such amount to the HPPC. Small employers could, but would not be required to, pay for a portion of the cost of health care coverage for their employees. Failure on the part of a small employer to have a HPPC agreement in effect or to comply with the agreement would result in a civil penalty not to exceed $500 for each day in which the violation continues.

Large employers would be required to make health care coverage available to employees through one or more AHPs but would not be permitted to do this through a HPPC. Large employers could, but would not be required to, pay for a portion of the cost of coverage for its employees. Large employers would be required, at the request of an employee, to deduct the cost of health care coverage under an AHP from employees' compensation and forward the premiums to the AHP. Failure on the part of a large employer to offer coverage under an AHP or provide for payroll deduction of premiums at the employee's request would result in a civil penalty not to exceed $500 for each day in which the violation continues.

D. Accountable Health Plans (AHPs)

The bill would not require health plans or providers to meet any specific requirements. However, the bill would encourage providers and insurers to provide coverage through AHPs by conditioning certain tax incentives on the purchase of health care through an AHP. AHPs could be either "open" or "closed". In general, a closed AHP would be an AHP that is limited by structure or law to one or more large employers. An open plan would be a plan that is not closed.

To qualify as an AHP, a plan would be required to meet quality standards to be established by the Commission, to offer a uniform set of benefits to be established under the bill, to establish standard premiums for the uniform set of benefits, and to make adjustments in cost-sharing in the case of low-income individuals. An AHP could offer benefits in addition to the uniform set of benefits, but only if the additional benefits were offered and priced separately from the uniform benefits.

In offering the uniform set of benefits, an AHP could not discriminate with respect to enrollment or benefits based on an individual's health status, claims experience, receipt of health care, medical history, receipt of public subsidy, or any characteristic that may relate to the need for health care services. An AHP would be allowed to exclude coverage with respect to a pre-existing condition for no more than six months

beginning on the first date of coverage under the plan.

AHPs would be required to charge a standard premium for the uniform set of benefits within each HPPC in which the plan is offered. The premium could vary only by premium class. The Commission would establish premium classes based on four types of enrollment (i.e., individual, individual and spouse, individual and one child, individual and more than one family member) and the age of the principal enrollee. Closed AHPs would be permitted to set premiums based on type of enrollment only (i.e., closed AHPs could disregard the age adjustment).

As discussed below, premiums would be reduced for low-income individuals.

E. Tax Incentives Relating to the Purchase of Health Plans

1. Excise tax on employers with excess health plan expenses

The bill would impose a deductible excise tax on employers equal to 34 percent of their excess health plan expenses. For this purpose, excess health plan expenses would include all expenses for group health insurance except certain expenses attributable to coverage under an AHP. Expenses attributable to coverage under an AHP would also be excess health plan expenses (1) if the employer's contribution is not uniform for a premium class regardless of which plan is selected by the individual, (2) if, in the case of a small employer, the payment is not made through a HPPC, and (3) to the extent the expense attributable to any particular individual exceeds the reference premium rate pertaining to that individual. The reference premium rate would be the lowest premium offered by an open plan in the HPPC area to individuals in the relevant premium class.

The excise tax would not apply to employer-provided health care for Medicare-eligible retirees or to expenses for direct services that are determined by the Commission to be primarily aimed at workplace health care and health promotion or related population-based preventive health activities.

The excise tax generally would be effective for expenses incurred after December 31, 1994, with a delayed effective date for expenses incurred pursuant to a collective bargaining agreement.

2. Increase in deduction for health plan premium expenses of self-employed individuals

On and after January 1, 1995, the bill would provide a 100-percent deduction for amounts paid by a self-employed individual to a HPPC for health care coverage for the individual and his or her spouse or dependents under an AHP, to the extent

the amount paid does not exceed the reference premium rate for the self-employed individual's premium class. Under the bill as drafted, no deduction would be allowed for the health insurance expenses of self-employed individuals during 1994.

3. Deduction for health plan premium expenses of individuals

Individuals would be able to deduct from gross income the cost of health insurance under an AHP up to the reference premium rate for the individual's premium class. Premiums that do not qualify for this deduction would continue to be deductible as under present law, i.e., subject to the 7.5-percent floor on itemized medical deductions.

The provision would be effective for amounts paid after December 31, 1994.

4. Exclusion of health care expenses from gross income

The bill would not change the present-law rule that employer contributions to an accident or health plan are excludable from an employee's gross income. The bill would extend this exclusion to partners and more than 2-percent shareholders of S corporations by providing that such individuals can exclude from gross income amounts paid by the partnership or S corporation for health care coverage of the partner or shareholder. Under present law, S corporation shareholders that own 2 percent or less of the corporation are permitted to exclude employer-provided health care from gross income.

The provision would apply to taxable years beginning after December 31, 1994.

5. Other provisions

H.R. 3222 (but not S. 1579) would provide for a liberalization of the rules governing when a health plan can qualify for tax exemption as a voluntary employees' beneficiary association (VEBA). The liberalized rules would apply only to health plans which are AHPs. H.R. 3222 would also provide for a simplified annual reporting system for certain fully-insured multiple employer welfare arrangements devoted solely to health care. The bill also would repeal the health care continuation rules for employers ("the COBRA rules"), generally effective on January 1, 1995.

F. Treatment of Underserved Areas

The bill would provide special treatment to areas designated by the Governor of the relevant State (with the concurrence of the Commission) as underserved. Under the bill, a HPPC serving an underserved area could require AHPs offered by

the HPPC to include the underserved area as part of their service area. Special risk-adjustment factors could be used to increase the compensation available to AHPs serving individuals in an underserved area. The bill would authorize $5 million in technical assistance funding for entities seeking to establish a network plan in an underserved area for each fiscal year 1995 through 1999. The bill would authorize $75 million for each fiscal year 1995 through 1999 for financial assistance with respect to the development and implementation of AHPs in underserved rural areas. The bill would authorize $11.5 million for each fiscal year 1995 though 1999 for migrant health centers and $88.5 million for each such fiscal year for community health centers.

The bill would expand Medicare Part B coverage to include certain services provided by rural emergency access care hospitals. The bill would authorize $50 million for each fiscal year 1995 through 1999 for transitional assistance to government-owned or private nonprofit safety net hospitals. The bill would establish a procedure whereby a State could identify an area as a chronically underserved area and arrange for it to be served by a single AHP.

G. Low-Income Assistance for Health Coverage

Low-income individuals could be eligible for some or all of the following subsidies under the bill: (1) premium assistance; (2) cost-sharing assistance; and (3) special assistance with respect to certain items and services (including prescription drugs, eyeglasses, and hearing aids). The types of subsidies available for any particular low-income individual would depend upon whether the individual is Medicare-eligible and whether the individual has very low income (family income below the poverty level) or moderately low income (family income below 200 percent of the poverty level).

Premium assistance would be available to all low-income individuals, whether Medicare-eligible or not. Cost-sharing assistance would be available to all low-income individuals who are not Medicare-eligible, and to very low-income individuals who are Medicare-eligible. Special assistance with respect to certain items and services would be available to all very low-income individuals, whether Medicare-eligible or not.

The total amount available for low-income premium assistance would be determined by the Commission for each year.

H. Medicare and Other Savings

The bill would make a number of changes relating to Medicare, including reducing certain provider payments under Medicare, requiring high-income individuals to pay an additional

premium for Part B of Medicare, and requiring certain agencies to prefund government health benefits. The bill would also repeal Medicaid.

I. Training and Education of Health Care Professionals

The bill would establish a National Medical Educational Fund to be used by the Commission to provide financing for certain medical residency training programs and physician retraining programs. Each AHP would be required to make a payment into the Fund of one percent of the gross premium receipts of the AHP. The bill would authorize appropriations for scholarship and loan repayment programs currently administered by the National Health Service Corps and funding for other grants.

J. Paperwork Reduction and Administrative Simplification

The bill would require the Commission to address certain issues relating to the use of health care information. Among other things, the Commission would be required to set goals and deadlines for the health care industry to take certain action regarding paperwork reduction and availability of information. A nondeductible penalty tax would be imposed on administrators of health plans for any failure to comply with the Commission's requirements.

K. Miscellaneous

The bill also contains provisions relating to the application of the antitrust laws to AHPs, preventive health and individual responsibility under public health plans, and malpractice reform.

II. ESTIMATED REVENUE EFFECTS OF TAX PROVISIONS IN THE MANAGED COMPETITION ACT (H.R. 3222 AND S. 1579)

The following tables show the estimated revenue effects of the various tax provisions in the Managed Competition Act for fiscal years 1995 through 2004. These revenue estimates were prepared by the staff of the Joint Committee on Taxation (Joint Committee staff) in cooperation with the Congressional Budget Office (CBO) as it prepared estimates of the outlay effects of the bill.

The major provisions of H.R. 3222 and S. 1579 would generally become effective on January 1, 1995. However, for purposes of estimation of the revenue and outlay effects of the bill, CBO and the Joint Committee staff have assumed that all effective dates would be postponed one year. Thus, the major provisions are not assumed to become effective until January 1, 1996.

The Joint Committee staff normally does not provide revenue estimates for fiscal years outside the standard five-year budget window (fiscal years 1995 through 1999), but an exception has been made for major health reform bills, for two reasons. First, the full impact of some of the provisions in the bills may not be apparent until the year 2000 or later. Second, the Congressional Budget Office has prepared baseline macroeconomic forecasts and baseline health expenditure forecasts through calendar year 2004 for the purpose of estimating the outlay effects of these bills. These macroeconomic forecasts are a necessary input for revenue estimation, and are not otherwise available for years outside the five-year budget window.

The Managed Competition Act would create a Health Care Standards Commission that would be responsible for determining the standard package of health insurance benefits that would be provided through accountable health plans (AHPs). Revenue and outlay estimates for some of the major provisions in the bill are very sensitive to the level of benefits provided through AHPs. For estimation purposes, CBO and the Joint Committee staff have made two alternative assumptions concerning AHP benefits. The revenue estimates for Alternative 1 were prepared under the assumption that AHPs would contain the same benefits as the standard benefit plan in the Health Security Act (H.R. 3600, S. 1757, S. 1775). The revenue estimates for Alternative 2 were prepared under the assumption that AHPs would contain a reduced benefits package that is 20 percent less expensive than the Health Security Act's standard benefit plan.

The Managed Competition Act would limit the favorable tax treatment of employer-paid health insurance by imposing an excise tax on excess health plan expenses of employers. Excess health

plan expenses would be defined as employer contributions that exceed the premium for the lowest-cost accountable health plan in the employer's Health Plan Purchasing Cooperative area. Since all AHPs would provide the same package of benefits, the variation in premiums for AHPs would likely be small. Thus, it is assumed that employers could pay a large portion of the premium for AHPs for their employees without incurring any excise tax liability. However, employer contributions toward supplemental health insurance (beyond the basic AHP) would generally be subject to the excise tax on excess health plan expenses. If AHPs contained a generous package of benefits (comparable to the standard benefit plan in the Health Security Act), then it is unlikely that many employers would provide supplemental health insurance, and excise tax revenues would be small (about $0.7 billion over the fiscal years 1996-2004), as shown in Alternative 1.

With a less generous benefits package (Alternative 2), it is likely that many employers would provide supplemental health insurance. Premiums for supplemental insurance could be paid by employees (through wage withholding) or by employers. If employers paid the premiums, there would most likely be a corresponding adjustment in the cash wages of the employees receiving the insurance. (Economists generally believe that all of the costs of employer-paid fringe benefits, including taxes imposed on employers, are borne by employees in the form of reduced cash wages.) Employer-paid premiums would be subject to the excise tax on excess health plan expenses, but employee-paid premiums would be paid out of cash wages that had been subjected to income and payroll taxation. In general, the excise tax would be less of a burden than the income and payroll taxes on cash wages, and it would be to the advantage of employees to have premiums for supplemental insurance paid by employers. Thus, with a less generous benefits package (Alternative 2), there would be larger excess health plan expenses by employers, and excise tax revenues would be much larger ($65.5 billion over fiscal years 1996-2004).

Some employers who are now making generous contributions toward health insurance for employees would reduce their contributions by amounts sufficient to avoid the excise tax on excess health plan expenses. These reductions would most likely be accompanied by increases in cash wages and other fringe benefits to maintain the same level of total employee compensation. The increases in cash wages would generate additional income and payroll tax revenues. These additional revenues are included in the last lines of the two tables ("Other tax effects..."), along with other tax effects of the bill. (The other tax effects would include changes in tax-sheltered health spending through cafeteria plans and changes in itemized medical deductions.)

If the excise tax were deleted from the bill, the revenue losses would be significantly greater than the $0.7 billion shown in Alternative 1 or the $65.5 billion shown in Alternative 2 because there would no longer be a disincentive for employers to pay for supplemental insurance for employees. A larger share of employer-sponsored health insurance would be paid by employers, with corresponding adjustments in the cash wages of employees, which would lead to reductions in income and payroll tax revenues.

The Managed Competition Act would provide individual taxpayers with a deduction from gross income for their expenditures on accountable health plan premiums. The deduction would be limited to the premium for the lowest-cost accountable health plan in the individual's Health Plan Purchasing Cooperative area, less any amounts paid by the taxpayer's employer. In general, a more generous benefits package for AHPs would result in larger individual tax deductions for AHP premiums and a larger revenue loss from the deduction. If AHPs contained the Health Security Act's standard benefit package, the revenue loss from the deduction would total about $165 billion over the fiscal years 1996-2004 (Alternative 1). With a less generous benefits package (Alternative 2), the estimated revenue loss from the deduction would fall to about $86 billion.

If the deduction were deleted from the bill, the revenue gain would be somewhat less than $165 billion (Alternative 1) or $86 billion (Alternative 2), for two reasons. First, some individuals would claim an itemized medical expense deduction for their insurance premiums (as allowed under present law, subject to a floor equal to 7.5 percent of adjusted gross income). Second, in the absence of the deduction, a larger number of employers would be willing to contribute toward health insurance for employees. These employers would make corresponding adjustments in the cash wages of their employees, which would lead to reductions in income and payroll tax revenues.

ALTERNATIVE 1:

ESTIMATED REVENUE EFFECTS OF TAX PROVISIONS IN THE MANAGED COMPETITION ACT (H.R. 3222, S. 1579) (1)

[HEALTH SECURITY ACT BENEFITS PACKAGE]

Fiscal Years 1995-2004

[Billions of Dollars]

Bill Section	Provision	Effective	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-04
1001	Excise tax on excess health plan expenses of employers (2)	eia 12/31/95	--	(3)	(3)	0.4	0.2	(3)	(3)	(3)	(3)	(3)	0 7
1002 -- 1003.	Deduction for health plan premium expenses of individuals (4)	1/1/96	--	-5.9	-15.2	-16.1	-17.2	-18.3	-20 2	-22 6	-23.9	-25 3	-164 7
1004	Exclusion from gross income for contributions by partnership or S corporation to health plans for partners and shareholders	tyba 12/31/95	--	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7	-0 8	-0 8	-0 9	5 9
1006.	Modify VEBA requirements to encourage group purchasing for large employers (5)	1/1/95	(6)	(7)	(7)	(7)	-0.1	-0 1	-0 1	-0.1	-0 1	-0 1	0 6
1601	Repeal of COBRA continuation requirements	1/1/96	*Negligible revenue effect*										
2204	Increase in Medicare part B premium for individuals with high income	ma/tyea 12/31/95	--	0 6	1 2	1 5	1.9	2 4	3 1	4 0	5 1	6 5	2[illegible]
6007	Excise tax penalty for failure to satisfy certain health plan requirements	tbdHCSC	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	[illegible]

Bill Section	Provision	Effective	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-04
	Other income and payroll tax effects relating to excise tax on excess health plan expenses of employers, deduction for health plan premium expenses of individuals, and other changes in private health insurance	1/1/96	--	2.8	5.1	5.2	5.7	6.1	5.6	5.5	5.5	5.7	47.3
GRAND TOTALS			**(6)**	**-2.9**	**-9.4**	**-9.5**	**-10.1**	**-10.5**	**-12.3**	**-14.0**	**-14.2**	**-14.1**	**-97.0**

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding

Legend for "Effective" column: eia = expenses incurred after
maityea = months after in taxable years ending after
tyba = taxable years beginning after
tbdHCSC = to be determined by Health Care Standards Commission

(1) Revenue estimates in this table were prepared under the assumption that accountable health plans contain the same benefits as the standard benefit plan in the Health Security Act (H.R. 3600, S. 1757, and S. 1775).

(2) If this provision were deleted from the bill, the revenue loss would be significantly greater than $0.7 billion because a larger share of employer-sponsored health insurance would be paid by employers and thereby excluded from income and payroll taxation.

(3) Gain of less than $50 million.

(4) Section 1002 would allow the self-employed to claim a deduction for their health insurance expenses, subject to the limits described in the text. Section 1003 would provide the same deduction to all individuals, including the self-employed. This line shows the revenue loss attributable to deductions that would be claimed by all individuals, including the self-employed. The omission of Section 1002 from the bill would have no revenue effect, because the self-employed would remain eligible for the deduction under Section 1003. If Sections 1002 and 1003 were deleted from the bill, the revenue gain would be somewhat less than $164.7 billion because households would claim larger itemized deductions for health insurance premiums and a larger share of premiums would be paid by employers (which would result in the exclusion of a larger portion of employee compensation from income and payroll taxation).

(5) This provision is not included in S. 1579.

(6) Loss of less than $10 million.

(7) Loss of less than $50 million.

(8) Gain of less than $1 million.

ALTERNATIVE 2:

ESTIMATED REVENUE EFFECTS OF TAX PROVISIONS IN THE MANAGED COMPETITION ACT (H.R. 3222, S. 1579) (1)

[REDUCED BENEFITS PACKAGE]

Fiscal Years 1995-2004

[Billions of Dollars]

Bill Section	Provision	Effective	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-04
1001	Excise tax on excess health plan expenses of employers (2)	eia 12/31/95	--	3.2	4 9	6.5	7 3	7 9	8.1	8 5	9.2	10 1	65 5
1002 -- 1003.	Deduction for health plan premium expenses of individuals (3)	1/1/96	--	-2.7	-6 9	-7.8	-8.9	-9 4	-10 7	-12 5	13.1	-13 9	-85 9
1004	Exclusion from gross income for contributions by partnership or S corporation to health plans for partners and shareholders	tyba 12/31/95	--	-0.4	-0.4	-0.4	-0.5	-0.6	-0 6	-0 7	-0 8	-0 9	-5 7
1006.	Modify VEBA requirements to encourage group purchasing for large employers (4)	1/1/95	(5)	(6)	(6)	(6)	-0 1	-0 1	-0 1	-0 1	-0 1	-0 1	0 6
1601	Repeal of COBRA continuation requirements	1/1/96	*Negligible revenue effect*										
2204	Increase in Medicare part B premium for individuals with high income	ma'tyea 12/31/95	--	0.6	1 2	1 5	1 9	2 4	3 1	4 0	5 1	6 5	2[illegible]
6007	Excise tax penalty for failure to satisfy certain health plan requirements	tbdHCSC	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	

Bill Section	Provision	Effective	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-04
	Other income and payroll tax effects relating to excise tax on excess health plan expenses of employers, deduction for health plan premium expenses of individuals, and other changes in private health insurance	1/1/96	--	4.6	6.8	7.1	7.8	8.4	8.1	8.2	8.4	8.8	68.2
	GRAND TOTALS		(5)	5.3	5.6	6.9	7.5	8.6	7.9	7.4	8.7	10.5	68.2

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding

Legend for "Effective" column: eia = expenses incurred after
ma'tyea = months after in taxable years ending after
tyba = taxable years beginning after
tbdHCSC = to be determined by Health Care Standards Commission

(1) Revenue estimates in this table were prepared under the assumption that accountable health plans contain a benefits package that is 20 percent less expensive than the standard benefit plan in the Health Security Act (H.R. 3600, S. 1757, and S. 1775)

(2) If this provision were deleted from the bill, the revenue loss would be greater than $65.5 billion because a larger share of employer-sponsored health insurance would be paid by employers and thereby excluded from income and payroll taxation.

(3) Section 1002 would allow the self-employed to claim a deduction for their health insurance expenses, subject to the limits described in the text. Section 1003 would provide the same deduction to all individuals, including the self-employed. This line shows the revenue loss attributable to deductions that would be claimed by all individuals, including the self-employed. The omission of Section 1002 from the bill would have no revenue effect, because the self-employed would remain eligible for the deduction under Section 1003 if Sections 1002 and 1003 were deleted from the bill, the revenue gain would be somewhat less than $85.9 billion because households would claim larger itemized deductions for health insurance premiums and a larger share of premiums would be paid by employers (which would result in the exclusion of a larger portion of employee compensation from income and payroll taxation).

(4) This provision is not included in S. 1579

(5) Loss of less than $10 million

(6) Loss of less than $50 million

(7) Gain of less than $1 million

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